Public Audit Committee

Thu 19 October 2023, 10:00 - 13:00

Velindre UNHS Trust Headquarters

Agenda

10:00 - 10:00
0 min

1.0.0 STANDARD BUSINESS

Led by Gareth Jones, Chair of the Audit Committee

1.1.0 Apologies

Led by Gareth Jones, Chair of the Audit Committee

1.2.0 In Attendance

Led by Gareth Jones, Chair of the Audit Committee

1.3.0 Declarations of Interest

Led by Gareth Jones, Chair of the Audit Committee

1.4.0 Draft Minutes from the Public Part A Audit Committee meeting held on 26 July 2023

Led by Gareth Jones, Chair of the Audit Committee

1.4.0 DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 26 JULY 2023-LF(GJ) (002).pdf (12 pages)

1.5.0 Action Log Public Part A Audit Committee

Led by Gareth Jones, Chair of the Audit Committee

1.5.0 Public Audit Committee Action Log updates for October 2023 Meeting.pdf (8 pages)

10:00 - 10:00
0 min

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

2.1.0a Audit Committee Private Patient Report Sep '23 01.10.23 (002).pdf (6 pages)
2.1.0b PP Action Plan 10.10.23.pdf (2 pages)

10:00 - 10:00
0 min

3.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

3.1.0 Trust Risk Register

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

3.1.0a TRUST RISK REGISTER -AUDIT - 1910.2023- vfinal2.pdf (8 pages)
3.1.0b Appendix 1 - DATIX REPORTS - V01 - 19.09.2023.pdf (4 pages)
3.1.0c Appendix 2 - DATIX REPORTS - V01 - 19.09.2023.pdf (2 pages)

3.2.0 Trust Assurance Framework

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

Following agreement in Trust Board in September meeting, out of Board action for Trist Assurance Framework to be progressed and reported to November Quality, Safety & Performance Committee and Trust Board.

3.3.0 Governance Assurance & Risk Governance, Assurance & Risk Programme of Work

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

- 3.3.0a GAR - AUDIT - 19.10.2023 - VFinal.pdf (9 pages)
- 3.3.0b GAR Steering Group Programme Update - UPDATED 11.09.2023 v2.pdf (11 pages)

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

- 3.4.0a Audit Action Tracker Cover Paper 19 October 2023 Audit Committee MB.pdf (14 pages)
- 3.4.0b Appendix 1 Red Overdue Recommendations Actions Audit Committee 19 October 2023.pdf (3 pages)
- 3.4.0c Appendix 2 Audit Action Tracker - Updated Sept 2023 - 19 October 2023 AC.pdf (19 pages)

10:00 - 10:00
0 min

4.0.0 EXTERNAL AUDIT

Led by Katrina Febry (Audit Wales)

4.1.0 Audit Position Update

Led by Katrina Febry and Dave Burridge (Audit Wales)

- 4.1.0 VUNHST Audit Cmt 202310 Audit Update.pdf (10 pages)

4.2.0 Audit Wales - Financial Accounts Memorandum Report

Led by Dave Burridge (Audit Wales)

- 4.2.0 3830A2023_Velindre_2022-23_Audit_of_Accounts_Addendum_- final.pdf (10 pages)

4.3.0 Audit Wales – Workforce Planning Report

Led by Katrina Febry (Audit Wales)

- 4.3.0 3684A2023_VUNHST_Review_of_Workforce_Planning_Report.pdf (30 pages)

10:00 - 10:00
0 min

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

- 5.1.0a VT 2324 Internal Audit Progress Report - Cover Paper v2.pdf (6 pages)
- 5.1.0b VT 2324 Internal Audit Progress Update - Oct-23 AC v2.pdf (4 pages)

10:00 - 10:00
0 min

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

- 6.1.0a Board Committee Report Cover Sheet PUBLIC.pdf (8 pages)
- 6.1.0b VELINDRE Q2 COUNTER FRAUD PROGRESS REPORT - PUBLIC.pdf (6 pages)

10:00 - 10:00
0 min

7.0.0 FINANCE

7.1.0 Private Patient Service Debt Position

Led by David Osborne, Head of Finance Business Partnering

- 7.1.0a Audit Committee - Aged Debt Private Patient Service Sept 23.pdf (7 pages)
- 7.1.0b Appendix 1 - Aged Debt Report Sept 2023.pdf (1 pages)

7.2.0 Losses and Special Payments Report

Led by Tracy Hughes, Head of Financial Operations

- 7.2.0 AC Losses and write offs paper Oct 2023.pdf (3 pages)

7.3.0 Receipt of Finance Technical Updates

Led by Tracy Hughes, Head of Financial Operations

No Technical Updates

10:00 - 10:00
0 min

8.0.0 CONSENT AGENDA

Led by Gareth Jones, Chair of the Audit Committee

8.1.0 ENDORSE FOR APPROVAL

Led by Gareth Jones, Chair of the Audit Committee

8.1.1 Amendments to Standing Orders / Standing Financial Instructions

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

- 8.1.1a Revisions to Trust Model SOs_SFIs_July 2023_Cover Report AC v1.pdf (6 pages)
- 8.1.1b GC02 v38 SOs Excluding Schedules_Sept 2023.pdf (45 pages)
- 8.1.1c GC02a v38 SOs Schedule 1_Sept 2023.pdf (24 pages)
- 8.1.1d GC02b v38 SO Schedule 2 Key Docs_SFIs_Sept 2023.pdf (79 pages)
- 8.1.1e GC02c v38 SOs Schedule 3_Sept 2023.pdf (65 pages)
- 8.1.1f GC02d v38 SO Schedule 4_Sept 2023.pdf (26 pages)
- 8.1.1g GC02e v38 Schedule 5 NWSSP MSO_July 2021_under review.pdf (108 pages)

8.2.0 FOR NOTING

Led by Gareth Jones, Chair of the Audit Committee

8.2.1 Procurement Compliance Report

Led by Matthew Bunce, Executive Director of Finance

- 8.2.1 Procurement Report to Sept 23 Final.pdf (23 pages)

8.2.2 Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria

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

- 8.2.2 Audit Committee_DOI, Gifts, Sponsorship, Hospitality and Honoria.pdf (10 pages)

8.2.3 Digital Strategy & Transformation Programme Audit Report

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

- 8.2.3a VT 2324 Digital Transformation Cover Paper.pdf (5 pages)
- 8.2.3b VT2324 02 digital tf final IA report.pdf (20 pages)

10:00 - 10:00
0 min

9.0.0 HIGHLIGHT REPORT TO THE TRUST BOARD

10:00 - 10:00
0 min

10.0.0 MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

10:00 - 10:00
0 min

11.0.0 ANY OTHER BUSINESS

10:00 - 10:00
0 min

12.0.0 DATE AND TIME OF THE NEXT MEETING

Tuesday 19 December 2023 at 10:00AM

10:00 - 10:00
0 min

13.0.0 CLOSE

MINUTES OF THE PUBLIC AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
WEDNESDAY 26 JULY 2023 AT 09:30AM

PRESENT:	
Martin Veale	Chair and Independent Member – items 1-7
Gareth Jones	Independent Member (and Chair from item 8 onwards)
Vicky Morris	Independent Member
ATTENDEES:	
Matthew Bunce	Executive Director of Finance
Lauren Fear	Director of Corporate Governance & Chief of Staff
Steve Ham	Chief Executive Officer
Chris Moreton	Deputy Director of Finance
Simon Cookson	Director of Audit & Assurance (NWSSP - Audit and Assurance Services)
Katrina Febry	Audit Wales
Steve Wyndham	Audit Wales
Gareth Lavington	Lead Local Counter Fraud Specialist
Lindsay Payne	Deputy Director of Finance and Corporate Services (NWSSP) – items 1-4
Jessica Corrigan	Business Support Officer

1.0.0	**Standard Business** Led by Martin Veale, Chair, and Independent Member	**Action**
	Introduction Led by Martin Veale, Chair, and Independent Member Martin Veale expressed thanks to the Committee for moving the start time to 9:30am and noted that he needed to leave the meeting at 12:00pm. Gareth Jones agreed to Chair following that time.	
1.1.0	**Apologies** Led by Martin Veale Apologies were received from: • Jacinta Abraham, Executive Medical Director • Tracy Hughes, Head of Financial Operations • Julie Winterburn, Senior Procurement Business Manager • Andy Butler, Director of Finance and Corporate Services • Richard Harries, Audit Wales	
1.2.0	**In Attendance** Led by Martin Veale Martin Veale welcomed attendees from Audit Wales and Internal Audit Services to the Audit Committee Meeting and noted that several people would be joining throughout the meeting to present their relevant items.	
1.3.0	**Declarations of Interest** Led by Martin Veale No declarations of interest were declared.	
1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 25 April 2023** Led by Martin Veale ****ACTION: Change wording:** **Section 5.1.0 "*good engagement during panning*" to "*good engagement during planning*".** **Section 7.2 "*In year had an abandoned claim for legal costs*" to "*In year the Trust had abandoned a claim for legal costs.*"** ****ACTION: Section 8.1.2 Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria - "*Martin Veale asked whether the list of declarations of interest was a complete list as it seemed some key employments were missing. Lauren Fear responded that the list should be a complete picture and that she will confirm on this back to the Committee.*"**	**AH** **LF**

	This Committee agreed this should be put on the Action Log for Lauren Fear to confirm. The AUDIT Committee **AGREED** the minutes of the meeting held on the 25 April 2023 subject to the minor noted amendments.	
1.5.0	**Action Log** Led by Martin Veale **07/2022 5.2.0 Trust Assurance Framework –** Lauren Fear advised no timescale exists for this action; been doing work in Executive Management Board to prioritise Business Intelligence (BI) work and in terms of prioritisation of work it's not high priority. Steve Wyndham confirmed discussions with Trust colleagues had taken place and it was decided Audit Wales didn't have the capacity to help but did provide leads in terms of potential sources of help. ****ACTION: Lauren Fear confirmed this was the original action and now it's being progressed with the team and this wording will be captured in the Action Log.** **The Committee agreed to close the action for Audit Committee and take to Board level to cover the totality in terms of the progress of the development of the BI function.** **Lauren Fear to confirm included and will forward for Trust Board agenda.** **01/2023 8.1.0 Private Patient Service Debt Position -** On the meeting agenda. **04/2023 3.4.0 Procurement Protocol - Notification of the Risk of Legal Challenge to the Award of All Wales Contracts Pursuant to the Public Contract Regulations 2015 (PCR 2015) –** The Committee agreed this action could be closed based on the meeting held 14 July 2023. Shared Services, Director of Procurement provided an updated Protocol which Independent Members are now comfortable with. The Committee proposed this be appended to one of the papers that go to the board (100K paper) with a paragraph within that paper so the Board are sighted on the process. Matthew Bunce will email Jonathan Irvine to say this has been agreed and welcome any comments. **04/2023 1.5.0 Action Log –** Wording to be tweaked to make the action clearer; that this refers to the Procedure on Policies "*POLICY ON POLICIES*" which relates to all other policies. The Committee were happy once changed the action could remain closed. The AUDIT Committee **AGREED** and **NOTED** all the **CLOSED** actions.	**LF**
	Gareth Lavington left the meeting at 9:40am	
2.0.0	**EXTERNAL AUDIT** Led by Steve Wyndham and Katrina Febry (Audit Wales)	
2.1.0	**Final Audit Plan** Led by Steve Wyndham and Katrina Febry (Audit Wales) Steve Wyndham highlighted to the Committee that in terms of financial audit, key areas of audit focussed on identified risks from the planning work. There were no issues or matters arising to report. The plan also sets out materiality levels, the timetable, and the audit fee with a 4.2% increase regarding the performance audit fee and a 15% increase regarding the estimated financial audit fee, due to undertaking additional work regarding ISA315. The plan provides details of the Audit Team, with Richard Harries as the new Engagement Director. Katrina Febry took the Committee through the 2023/24 programme of work in terms of performance Audit; proposing four reviews, • Structured Assessment; • deep dive into investment in digital, focussing on local arrangements to support investment in digital technologies, solutions, and capabilities; • follow up to the Quality Governance work from 2022, and • examination of the setting of well-being objectives. Karina Febry also explained there were two remaining pieces of work from the 2022/23 audit programme: • workforce planning	

	• operational governance	
2.2.0	**Audit Position Update** Led by Steve Wyndham and Katrina Febry (Audit Wales) • **Appendix - Good Practice Exchange** ****ACTION: Katrina Febry informed the Committee of the need to resubmit the audit update within the papers as there was one piece of work noted on there, but there are two pieces outstanding. First piece is workforce planning; being drafted currently and expected to be sent to the Trust in September 2023 for clearance. Other piece, would like to look at operational governance, looking at the interconnect from the divisions into Executive Management Board, this will be part 2023/24 programme.**	**KF**
2.3.0	**Public Sector Readiness for Net Zero Carbon by 2030 - Management Responses** Led by Carl James, Director of Strategic Transformation, Planning and Digital Martin Veale welcomed Carl James to the meeting to present this item. Carl James informed the Committee this call for action involved review and stocktake of the current approach over strategy plans and where the Trust is in terms of the overall delivery of the carbon reduction against the audit report. ****ACTION: 2.3b The Committee requested before publishing there is a need to make sense of some of the sentences and in the detailed action plan, to change the word "*waiting*" to "*weighting*" in relation to the Business Cases.** Gareth Jones raised the need for target dates to monitor progress and highlighted that on page 4 wording ***"To deliver such an ambitious goal the Trust is not currently resourced to deliver all aspects of sustainability. Furthermore, consistent investment in training and development."*** wasn't clear and questioned if this would be addressed in the action plan right hand column? Carl James assured the Committee that these are being worked into existing action plans and they will have dates against them. There is a detailed decarbonisation plan and that this could be provided outside of meeting. He commented that there are challenges regarding resources particularly around the cultural behavioural issues and training and education resources. Broader conversation ongoing in NHS Wales about how to collaborate in order to make the best use of the resources which the system collectively has. To make sure people see what is being done Carl James noted that there are regular internal communications and one of the opportunities is the Board are visibly championing sustainability. Lauren Fear confirmed this in terms of public visibility, there continues to be consistent messaging relating to the Hefyd programme. Carl James informed the Committee in response to how this will be monitored going forward that it is part of the Trusts core business and the key metrics are reflected in the Performance Management Framework. ****ACTION: Carl James to circulate the detailed Decarbonisation Plan to the Audit Committee outside of the meeting.**	**CJ** **CJ**
3.0.0	**CONFIRMED FINAL ACCOUNTS -** **ACCOUNTABILITY REPORT & ANNUAL ACCOUNTS 2022-23**	
3.1.0	**Cover Paper for Accountability Report & Annual Accounts 2022-23** Led by Emma Stephens, Head of Corporate Governance and Chris Moreton, Deputy Director of Finance	
3.2.0	**Accountability Report for 2022-23** Led by Emma Stephens, Head of Corporate Governance Martin Veale welcomed Emma Stephens to the meeting to present this item. Also noting that Sarah Morley had joined to address any questions in relation to the Remuneration and Staff Report. Emma Stephens took the Committee through the report:	

	- Corporate Governance Report – Compared to last year's report it talks about the reduced impact of the Covid pandemic and some of the learning and changes. - Director's report - April 2023, Stephen Harries was permanently appointed as Vice Chair. Recent amendments to the portfolio of the Director of Planning and Digital to an Executive Director. Further review has been undertaken in terms of governance arrangements in terms of the shared Services Partnership following the introduction of the Duty of Quality and Duty of Candour to reflect the governance arrangements required in terms of Quality Safety and Performance Committee and those will continue to be further developed moving on to this new reporting period. ****ACTION: Governance Statement for Shared services and HTW were provided in draft format at the April 2023 Board Development Session. Emma to forward for completeness final copies to the Board and circulate to Audit Committee Members.** In relation to questions raised around the Risk Register (Page 46) Lauren Fear specifically checked the Asda risk and confirmed this was in the public domain. ****ACTION:** • **Risk Register page 46 – In relation to the current rating and the target rating and the fact that sometimes they are substantially different, the later column to be removed.** • **Executive Directors section, the Committees they attend is to be corrected. For the Information Governance section detail around some of incidents and process, and ICO details need amending. Matthew Bunce will confirm these changes to Emma Stephens.** • **Appendix 2 page 74 - Director and Independent Members column champion roles are different to areas of expertise. Needs to be amended.** • **Internal Audit Section pages 54-57 reflect what is in the opinion so that it is consistent. The Committee agreed that there is not a need to go into in detail rather just reflect on the on limited assurance report and refer to the reports.** Steve Ham agreed to capture some bullets points for Martin Veale to have an update for Trust Board 27 July 2023. To make the one change today, publish and recommendation agreed by the Committee to be to endorse for Trust Board approval subject to these various changes, subject to what Trust Board agrees to make sure all signed off by the 31 July 2023. Steve Wyndham noted that he has also communicated a couple of areas of report that need tweaking, mainly cross-referencing figures of revised accounts. Emma Stephens confirmed that Steve Coliandris was in the process of making those amendments with the cross reference to the accounts detail in relation to that contained in the remuneration report. This will be included in the briefing note for Trust Board. -Financial Accountability Report – Met financial duties, targets, the breakeven revenue duty, capital expenditure limit, paired with the 3-year integrated plan which was signed off by the Minister. -Remuneration and Staff Report - There were no questions from the Committee on this section. Martin Veale noted the Table, Page 92 should probably read Donna Mead, Stephen Harries and then Martin Veale.	**ES** **ES**
3.2.0A	**Velindre University NHS Trust Final Accounts 2022-23** Led by Chris Moreton, Deputy Director of Finance Chris Moreton reflected on the economic context of the financial year, stating the high level of uncertainty and ambiguity generated by political and social events throughout and highlighted the following key aspects of the report to the Committee: • Submitted draft statutory accounts to Welsh Government and Audit Wales 05 May 2023. • Received the Audit Plan as an outlined plan at the April Audit Committee, expected to receive a detailed plan in May 2023, which was finalised in June 2023. Deadline for Audit Wales to complete the audit was extended to 31 July 2023 and it is expected that will be able to be met. • The outcome of the process is an unqualified audit opinion. Chris Moreton highlighted the key changes since submission for the draft accounts independent members received 15 May 2023: • Welsh Risk Pool provisions have been corrected to £4.587 million from £14.587million.	

	• Property planning equipment – note 13 £7million adjustment, increasing the net book value of the Trusts Property Plant Equipment. • An associated depreciation charge movement which has been aligned with Welsh Government so had no impact on the Trusts financial position. Chris Moreton highlighted in relation to Statutory duties - Financial duties break even. To note the external financing limit was suspended in 2022-23 and were notified about this by Welsh Government on 01 April 2023. Public Sector Payment Policy – The Trust paid 95.6% non-NHS bills within the target of 95%. The Committee noted this being the first unqualified opinion since 2019/20, the two subsequent qualifications were due to external circumstances.	
3.2.0Bi	**Appendix 1 - Letter of Representation 2022-23** Led by Matthew Bunce, Executive Director of Finance	
3.2.0Bii	**Appendix 2 - Audit Wales Governance Statements Factsheet and Observations** Led by Chris Moreton, Deputy Director of Finance and Emma Stephens, Head of Corporate Governance	
4.0.0	**CONFIRMED FINAL ACCOUNTS -** **AUDIT WALES – AUDIT OF FINANCIAL STATEMENTS** Led by Steve Wyndham (Audit Wales)	
	AUDIT WALES ISA 260 REPORT Led by Steve Wyndham (Audit Wales) Steve Wyndham highlighted the following main points in the report: • Page 4,IT audit document requests are on track to being actioned. File review on completion of the audit given still some elements of the audit ongoing. Confident that will be complete by 31 July 2023. View that is very likely will result in an unqualified opinion for 31 July. • There are no incorrected misstatements. All the issues and wording issues, narrative and numerical issues found have been addressed and corrected by management. • Appendix 3 - Delays experienced in the audit this year. Experienced slippage, an extension in the audit window, issues in terms of late starting of the audit and dealing with ISA 315 and dealing with secondment and sickness. Worked collaboratively to navigate through the issues. . Martin Veale expressed that it would be helpful for the Appendix 3 paragraph 14 to reference that none of this effected the final audited numbers. It would also be helpful to have a section on the areas of inefficiencies and issues Audit Wales had with staffing. Steve Wyndham responded that staffing contributed to a challenging auditing period but didn't contribute to the delay in completion as the audit was done within a three-month window. Matthew Bunce thanked Steve Wyndham and Lyndsay Payne and their teams for the work which contributed to the audit. Steve Wyndham also noted to the Committee the teamwork involved. Following consideration of items 3.0.0 and 4.0.0 the AUDIT Committee: **NOTED** the contents of 3.2.0 Accountability Report and 3.2.0A Annual Accounts for 2022-23, including the Letter of Representation (3.2.0Bi Appendix 1) and Trust Response to Audit Wales regarding Trust Governance and Management Arrangements (Appendix 2 3.2.0Bii). **ENDORSED for BOARD APPROVAL** the Accountability Report **subject to the points and changes noted.** **EDORSED for BOARD APPROVAL** the Annual Accounts for 2022-23 and ISA 260.	
5.0.0	**PRIVATE PATIENT SERVICE REVIEW** Led by Matthew Bunce, Executive Director of Finance	
5.1.0	**Actions Update Report** Led by Matthew Bunce, Executive Director of Finance Martin Veale welcomed David Osborne to the meeting to help support this item.	

	Matthew Bunce advised following employing Liaison to help with private patients and that significant work to move forward on the actions in the action plan has taken place. Proposing to extend Liaison's work with the Trust until the end August 2023 until the material items identified in the action plan are fully completed. Liaison has been involved in the planning work in terms of negotiation with the significant insurance providers and over the next few months will be engaging with those insurance companies. There has been significant work in terms of reviewing the billing historically over the past two years. Identified nearly £500,000 potentially of income. Letters have been sent to insurers setting out claims but haven't had responses back yet. In future the team will reflect this in the billing. There has been a lot of work tightening up processes with their experience of working across the UK with private patients, including policies, procedures, and processes. Liaison are also providing insight in terms of analytics. 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. The priority over all this period is working between the Debtor's Team and the Private Patient Service to undertake that exercise. David Osbourne responded to the Committee in relation to having an age profile that some of debts are greater than six months, £150,000 plus is in relation to the last six months. £300,000 is spread over the last two years so it does come with a risk, but the statement of accounts has gone out to those insurers to advise them so there is a proportionate risk against it. Matthew Bunce assured that Liaison have challenged insurers companies before and have been successful in challenging back for two years. In relation to target dates, the Committee were informed there is a weekly progress meeting which works to ensure that the action plan to be completed by end August 2023. Whilst deadline has been extended for Liaison, this is within the financial envelope agreed so the deployment is still within the original financial quantum agreed. Matthew Bunce stated that the Committee has asked for a report from Liaison listing all the actions and outcomes and they will do that as a full report on conclusion for the October 2023 meeting. The AUDIT Committee **NOTED** the highlights from the Private Patient Improvement Group meeting held during February and May 2023 periods. **APPROVED** the amended Private Patient Improvement Plan and **AGREED** to oversee the implementation of the financial and commercial improvements. **NOTED** the progress of Liaison Financial Services external expert support for the areas identified in the improvement plan	
6.0.0	**VUNHST CLINICAL AUDIT ANNUAL REPORT 2021-2023** Led by Zoe Gibson, Interim Head of Quality Safety and Assurance	
	Discussed at 11:31am Martin Veale welcomed Zoe Gibson to the meeting to present this item. Zoe Gibson took the Committee through the report stating that it is a two-year report due to the Covid pandemic and the inability to publish one for the previous year and is the first of its type being a truly integrated approach to clinical audit which includes the audit outputs from both Velindre Cancer Service and the Welsh Blood Service. It describes the internal and external audit undertaken during the period and demonstrates the diversity of the clinical audits and the range of clinical audits that are currently in place. Zoe Gibson informed the Committee that the report has reasonable assurance with five actions identified. All the outputs of the annual report have informed the development of the Trust Clinical Audit Plan that has been constructed for the financial year 2023-2024. Quality, Safety and Performance Committee have received the report and felt positive in terms of development but did ask that one of the 7 levels of assurance be added to the report before it goes to Trust Board, Vicky Morris was happy to pick up with Zoe Gibson outside of the meeting. The AUDIT Committee **NOTED** the report.	

7.0.0	**INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING**	
7.1.0	**Trust Risk Register** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff *Discussed at 11:19am before item 6.0.0.* Lauren Fear informed the Committee that the latest version of the Trust Risk Register was presented to Quality Safety and Performance Committee (QSP) and will be going to Trust Board 27 July 2023. The discussion at QSP was that there is a change to the assurance rating since the last time Audit Committee received the report. Following concerns raised around the length of time some risks are outstanding with no indication of a target date to mitigate the risk, Lauren Fear specified that it has not been explicitly agreed with risk owners to specifically give a date when target risk score will be achieved but confirmed she would add this as part of the on-going development of the work. Lauren Fear confirmed in relation to a query, the governance route of risk 3011 is approval at Executive Management Board for closure of risk, however this needs to made clearer in the reporting template. ****ACTION: Risk 3138 – The Committee questioned if this risk be in the public domain or private? Lauren Fear to look at the wording of this risk. A few dates in the date column are now in the past so this will be investigated.** The Committee were asked to note in relation to the Cover paper 4.3; QSP have discussed the cumulative risk of the separate digital systems, the challenges in BI and the manual resource of clinical staff to manage information. It was agreed that where in depth discussions are taking place on specific risks at QSP on scheduled agendas, Audit Committee should be invited to those sessions. In relation to 4.4 Mandatory Training, Lauren Fear noted the Trust has six months, to end October 2023 get to 85% on compliance rates. 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 and **NOTED** the on-going developments of the Trust's risk framework.	**LF**
7.2.0	**Governance Assurance & Risk Governance, Assurance & Risk Programme of Work. (Verbal Update)** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff *The Audit Committee went back to this item following item 6.0.0 at 11:38am.* Lauren Fear highlighted to the Committee the 21 projects under this programme of work and the time taken on updating all of these actions and their status. Work completed has included training on Board Papers and the paper template of the Governance Manual. ****ACTION: Once the final version is ready this needs to be reviewed in the Steering Meeting with Gareth Jones as the Independent Member Lead and Nicola Williams as the Executive Lead and then it will be shared with the Audit Committee via email.**	**LF**
	Emma Rees joined the meeting at 11:43am and left following item 8.0.0.	
7.3.0	**Review of Audit Action Tracker – Overdue and Completed Recommendations / Actions from Internal & External Audit** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce took the Committee through the Audit Action Tracker Report. Executive Management Board have considered the report in terms of the extension dates asked for and have agreed that those of green status actions to be closed. Matthew Bunce went through the status of the overdue actions that he is responsible for. Delegation letters for budget holders have been sent from the Chief Executive to the Chief Operating Officer and to the Directors, and final step is regarding the delegation below that. This also links to the second point about adjusting financial control; procedures to reflect a timescale of when the budget delegation goes out. That's also included in the pack and it's been amended to reflect April 2023 but all of that is subject to the Integrated Medium-Term Plan being signed off by Welsh Government in July 2023 and the Commissioners signing off the LTS with the deadline for the end of June 2023.	

	Vicky Morris noted in relation to Review of Quality Governance overdue action, that she wanted to raise the quality goals and the 5-month length of time to turn into SMART actions or objectives, within the Integrated Medium-Term Plan and confirmed she would discuss this with Nicola Williams. Gareth Jones highlighted the importance of the Structured Assessment overdue action, and that there was no extension date or extension in months sought. There appears to be a growing importance on digital across the piece and Welsh Government is becoming particularly interested in it so this is something that does need to move forward at pace. ****ACTION: The Committee agreed to task Matthew Bunce to ask Nicola Williams and Carl James to provide updates on their overdue actions outside of the meeting.** Matthew Bunce noted to the Committee that since the paper went to June 2023 Executive Management Board, further updates have been sought and there have been 15 further actions turned to green / complete status. The AUDIT Committee **NOTED** the progress and **APPROVED** 24 Internal and six External actions to be changed to closed (blue status). Noting nine of these were approved to change to closed through Chairs Urgent Action. **NOTED** the two Internal and two External actions and **APPROVED** the extension dates identified. The Committee **AGREED** Finance & Service Sustainability item 3.2 could be marked as closed.	**MB**
	Vicky Morris requested an update on the Trust Assurance Framework as this was the second Audit Committee where it wasn't received. Lauren Fear updated the Committee that the two things in progress are the refresh of the template which was part of the offline work that was done prior to the April 2023 meeting of the Audit Committee and secondly the refresh of the risks themselves. The refresh of the risks themselves has been to Executive Management Board. It was discussed at the last Strategic Development Committee and an approach has been agreed with the divisions at Board Development which was to do a reverse stress testing with the divisions as two separate exercises. The Welsh Blood Service work is complete and within Velindre Cancer Service one good session has taken place but there was another needed. On conclusion of this, the work with the owners on the new template will be brought to Strategic Development Committee and then September 2023 Board. The Committee agreed it's important for the Audit Committee to have a regular review of the Trust Assurance Framework, which needs to be owned by the Board even if nothing has changed.	
8.0.0	**INTERNAL AUDIT** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)	
8.1.0	**2022/23 Final Annual Report & Head of Internal Audit Opinion** Led by Simon Cookson, Director of Audit & Assurance, NWSSP (Audit and Assurance Services Simon Cookson took the Committee through this item, noting it was a positive report with good reasonable assurance based on three substantial, ten reasonable, one limited and three advisory assurance ratings. The Velindre Cancer Centre work programme remains fluid because there is a need to adapt as timelines change. Some work was deferred over the year and will be picked up next year. Report also includes the national audits conducted at Shared Services and DHCW that have an impact in helping form the opinion overall. Simon Cookson thanked Steve Ham and his team, all the officers and the Audit Committee, recognising all the pressures, for working collaboratively to get to a conclusion with a positive outcome. Steve Ham highlighted the helpful dialogue from Emma Rees in Executive Management Board. Matthew Bunce informed regular meetings with Internal Audit help to keep on track collectively. The AUDIT Committee **NOTED** the report.	
8.2.0	**2023/24 Internal Audit Progress Update** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) In terms of the 2023/2024 Audit plan, Emma Rees highlighted a couple of changes requesting approval:	

	• IRS Implementation Review originally was a standalone audit and then there was a capital assurance element where the scope had yet to be determined. It has now been decided that the IRS Implementation will be the Capital Assurance piece and that the governance assurance and risk programme will replace it. This has been discussed with Lauren Fear and endorsed for approval by Executive Management Board at the end of June 2023. Emma Rees confirmed, in response to a question as to whether this was a consistent approach taken elsewhere, that no one else is doing the specific IRS implementation work. However, the scope of the capital assurance piece is decided in year and picks up on a major piece of capital work that isn't necessarily covered by an IWAP. This approach is similar to what is done in other organisations. • Cancer Centre IAAP, originally had five audits from last year deferred into this year in alignment with progress on the IAAP; however since then Internal Audit has discovered that there are external parties doing work in two of those areas that would duplicate what was planned. Proposed that the Design and Change Management and Procurement Reviews be cancelled. Emma Rees informed the Committee that management responses target is 80% and the Key Performance Indicator turns from green to amber at 70%. They have done some analysis around the numbers which do need to be shared with Executive Management Board around where the delays are or whether any trend exists for hotspots. None of them are a month past the original deadline. In relation to the executive summary action requiring greater support from Executive Management Board to ensure the provision of timely comments and management responses, Emma Rees confirmed Steve Ham is working closely with Internal Audit. Emma Rees noted to the Committee the Key Performance Indicators are reset every year but stated that as Velindre is a smaller organisation, one report missing could have a big impact. She would like to see that throughout the year the Trust doesn't dip down again so that it will be where required by the end of the year. Gareth Jones stated that the recommendation / action on the Cover Report, Bullet point 3 *"**IDENTIFY** if there is any action that can be taken to support improvement in timeliness of management responses"* is not for the Committee to identify and it is for the Trust to take. Emma Rees agreed she could list the actions that have been taken and then add in then anything that Executive Management Board specifically asks to do and will provide an update at the October 2023 Audit Committee. The AUDIT Committee **NOTED** the report and **APPROVED** the proposed changes.	
	Steve Ham left the meeting 12.10pm.	
9.0.0	**COUNTER FRAUD**	
9.1.0	**Counter Fraud Progress Report Quarter 1 23/24** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Lavington highlighted the four main areas of work: • Promotion activity – Pop ups and holding webinar events. Advertisement through SharePoint sites / communications. eLearning Package is live on ESR system but is not mandatory. • Prevention activities – One local bulletin issued in relation to false references being supplied by a member of staff of a recruitment agency. One hyper notice was issued in relation to a finance manager subcontracting work to multiple NHS various organisations. No issue identified for Velindre. Investigated four referrals with two remaining open. • Fraud risk – Carried out four fraud risks risk assessments; all have been disseminated to the organisation. Closed two, on Datix and recorded accordingly and recommendations have been made. Continue work in relation to the National Fraud initiative and the report gives a breakdown of the areas where investigations have been undertaken. The Trust is only responsible for the numbers in the brackets. • Corporate induction – At the time of writing this report, Counter Fraud was due to give a session at the WBS on 19 July which was withdrawn. He had also been made aware that the Executive Management Board decided that Counter Fraud would be taken off the Corporate Induction	

	Programme. Have arranged meetings with Claire Budgen to discuss further what we can do to raise awareness and had a meeting with Ian Bevan with regards to whether can work together for a corporate induction. Matthew Bunce confirmed the Executive Management Board discussion; as part of the induction there would be a pack of information and to also summarise in one slide all of the areas of mandatory training that new joiners are required to do. Ian Bevan and Gareth Lavington to discuss having something that then takes the list of those inductees to run a special training session for Information Governance and Counter Fraud within the first three months as a requirement. Matthew Bunce will then work with the Workforce Team to ensure counter fraud is part of mandatory training. In relation to the National Fraud Initiative and the figures in brackets, Gareth Lavington confirmed that five were cleared in relation to 20 in Velindre. Matthew Bunce explained he would like to review potential inaccuracies in the appendices. Fraud risk assessment stated that Velindre did not provide any of the information and stressed the need to make sure the other two risks flagged get onto Datix. Gareth Lavington confirmed he has had a meeting with Lauren Fear on this and they are following the correct process. In relation to the inaccuracy referring to DHCW being part of Velindre, Gareth Lavington confirmed that has been raised at the DHCW Audit Committee and clarified with Counter Fraud Authority. The AUDIT Committee **RECEIVED** and **DISCUSSED** the report.	
10.0.0	**FINANCE**	
10.1.0	Private Patient Service Debt Position Led by David Osborne Head of Finance Business Partnering David Osborne gave apologies for Rachel Hennessy. Gareth Jones welcomed David Osborne back to the meeting to present this item. David Osborne highlighted the following key points to the Committee: • Been a deterioration in the age debt position largely due to vacancies within the private patient service team. • Support from Liaison now targeting the age debt profile over the next period. • Gone through age debt profile to understand the majority of the £600,000 greater than six months' position, and a majority of that no less than £300,000 is within accounts. • Majority of debt greater than 6 months has been received by the Trust, though remains in an "unallocated fund", as the detail provided by the funder has been insufficient to identify the specific debt it relates to. Liaison and our Debts Team are working jointly on allocating the received funds to matched debts and thusly reducing the quantum of aged debt. Matthew Bunce informed the Committee have a Debtors Team established. Expecting a Private Patient Team that have not had experience in debt collection and understanding how to allocate cash, so there's a lot of work getting the Central Debtors Team involved in allocating the cash and working closely with the Private Patient Team making sure it doesn't build up as unallocated. David Osborne assured he would take on board the comment in terms of understanding any length of delay prior to the invoice being raised will take that as a review in terms of whether can add anything to the Key Performance Indicator to that effect. ****ACTION: Chris Moreton and David Osborne to assess whether the Corporate Finance Debtors Team has capacity to support the Private Patient Service in Debt Collection.** The AUDIT Committee **NOTED** the report.	**CM and DO**
	Gareth Lavington left the meeting at 12:23pm	
10.2.0	**Losses and Special Payments Report** Led by Chris Moreton, Deputy Director of Finance Chris Moreton highlighted to the Committee the four bad debts written off which relate to NHS bodies that are no longer in existence. Had an abandoned claim for legal costs which was approved by Welsh Government in relation to the new Velindre Cancer Centre of £337,000. Section 2.6 Matters for Consideration sets several smaller items which come through the losses and compensation procedure total value less than £2,500.	

	****ACTION: Gareth Jones raised the question in relation to the NHS England Debts are there are successor bodies to these organisations that have ceased to exist? Chris Moreton clarified he would need to check and assumed would have been picked up in the process of signing them off. Gareth Jones requested to not spend too much time on this.** The AUDIT Committee **NOTED** the report.	**CM**
11.0.0	**CONSENT AGENDA** Led by Gareth Jones, Acting Chair of the Audit Committee	
11.1.0	**ENDORSE FOR APPROVAL** Led by Gareth Jones, Acting Chair of the Audit Committee	
11.1.1	**Variation to Standing Orders Velindre University NHS Trust** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Vicky Morris noted it was helpful to see track changes but would have expected PHW and WAST references to be removed before final version. ****ACTION: Need to note the model and standing orders have now been caught up, to not ask for approval of the Non-Executive Director section twice as this was amended in April 2023. Page 8 new section vii first bullet to be changed to read "*ensuring NHS bodies and ministers think about the quality*" rather than "*NHS bodies and ministers to think about the quality*". Second bullet to be changed to "*honest with patients*" rather than "*honest with patents*".** The AUDIT Committee **ENDORSED FOR APPROVAL** subject to amendments noted.	**LF**
11.2.0	**FOR APPROVAL** Led by Gareth Jones, Acting Chair of the Audit Committee	
11.2.1	**Financial Control Procedure Update** • **FCP 1 – Budgetary Control procedure** Led by Matthew Bunce, Executive Director of Finance ****ACTION: Cover paper 2.1 to say last review undertaken December 2022 not December 2023.** Matthew Bunce informed the Committee that the change was in relation to the recommendation from Internal Audit which is now closed on the Audit Action Tracker. The AUDIT Committee **APPROVED** the changes.	**MB**
11.2.2	**Chair's Urgent Action** • **Audit Action Tracker - Closure of the nine Complete (Green Status) Actions formally Closed (Blue Status)** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The AUDIT Committee **CONSIDERED** and **RATIFIED** the Chair's urgent action.	
11.3.0	**FOR NOTING** Led by Gareth Jones, Acting Chair of the Audit Committee	
11.3.1	**Procurement Compliance Report** Led by Matthew Bunce, Executive Director of Finance The AUDIT Committee **NOTED** the report.	
11.3.2	**Follow Up of Previous Recommendations** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) The AUDIT Committee **NOTED** the report.	
11.3.3	**Trust Priorities** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Simon Cookson informed the Committee this was a positive report. Given this is a long-term strategy it is in part anticipating some of the actions that will be needed in the medium term.	

	****ACTION: Recommendations / Agreed management actions. Specifically in relation to Page 11 of the report Matter Arising 2 Risks to Delivery – Finance and Resourcing. The Committee felt the agreed management action repeats the recommendation and doesn't say what the agreed action will be. The Committee requested more detail as to how going to deliver or meet the recommendations. To be addressed outside of meeting.** The AUDIT Committee **NOTED** the report subject to the above comment.	**CJ**
11.3.4	**Audit Committee Cycle of Business** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The AUDIT Committee **NOTED** the contents of the Cycle of Business plan for 2023/2024.	
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 28 September 2023.	
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**	
	Thursday 05 October 2023 at 10:00am.	
13.0.0	**CLOSE**	
	The meeting CLOSED at 12:44pm.	

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 12 January 2022 Meeting			
01/2023 8.1.0	**Private Patient Service Debt Position** **ACTION: The Private Patient Debt Position is to be reviewed to establish the Key Performance Indicators and target performance indicators. For the next Audit Committee develop a formal set of targets to go with the indicators to see whether those indicators are the most appropriate ones.**	**ACTION: Rachel Hennessy / David Osborne**	**OPEN** **Update September 2023** Meeting scheduled for September with BI to look at identifying the requirements for a system that would enable aged debt to be capture electronically. **Update JULY 2023:** Further work required on definitions which will need to be agreed by PP improvement group. Issues in relation to sickness and resource to support. **Update APRIL 2023:** Proposed KPIs in draft. Ongoing discussions regarding resource to produce report as significant requests to BI and impact of DHCR limiting resource available.	**RH**

	Actions from 26 July 2023 Meeting			
07/2023 1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 25 April 2023** **Change Wording:** **Section 5.1.0 "*good engagement during panning*" to "*good engagement during planning*".** **Section 7.2 "*In year had an abandoned claim for legal costs*" to "*In year the Trust had abandoned a claim for legal costs.*"**	**ACTION: Alison Hedges**	**CLOSED** **August 2023:** The wording has been changed on the confirmed minutes.	**AH**
07/2023 1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 25 April 2023** **Section 8.1.2 Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria -** **"*Martin Veale asked whether the list of declarations of interest was a complete list as it seemed some key employments were missing. Lauren Fear responded that the list should be a complete picture and that she will confirm on this back to the Committee.*"** **This Committee agreed this should be put on the Action Log for Lauren Fear to confirm.**	**ACTION: Lauren Fear**	**CLOSED** **September 2023:** Declaration of Interest record reissued to AW for inclusion of Cardiff University role and updated accordingly.	**LF**
07/2023 1.5.0	**Action Log** **Trust Assurance Framework –** Lauren Fear advised no timescale exists for this action; been doing work in Executive Management Board to prioritise Business Intelligence (BI) work and in terms of prioritisation of work it's not high priority. Steve Wyndham confirmed discussions with Trust colleagues had taken place and it was decided Audit Wales didn't have the capacity to help but did provide leads in terms of potential sources of help.	**ACTION: Lauren Fear**	**CLOSED** **September 2023:** Governance route for BI update agreed.	**LF**

	****ACTION: Lauren Fear confirmed this was the original action and now it's being progressed with the team and this wording will be captured in the Action Log. The Committee agreed to close the action for Audit Committee and take to Board level to cover the totality in terms of the progress of the development of the BI function. Lauren Fear to confirm included and will forward for Trust Board agenda.**			
07/2023 2.2.0	**Audit Position Update Katrina Febry informed the Committee of the need to resubmit the audit update within the papers as there was one piece of work noted on there, but there are two pieces outstanding. First piece is workforce planning; being drafted currently and expected to be sent to the Trust in September 2023 for clearance. Other piece, would like to look at operational governance, looking at the interconnect from the divisions into Executive Management Board, this will be part 2023/24 programme.**	**ACTION: Katrina Febry**	**CLOSED. September 2023:** Katrina Febry provided a revised update. The status of the workforce planning review to the audit update was added. This new version was circulated for information to the Audit Committee via email.	**KF**
07/2023 2.3.0	**Public Sector Readiness for Net Zero Carbon by 2030 - Management Responses 2.3b The Committee requested before publishing there is a need to make sense of some of the sentences and in the detailed action plan, to change the word "*waiting*" to "*weighting*" in relation to the Business Cases.**	**ACTION: Carl James**	**CLOSED September 2023:** The Public Sector Readiness for Net Zero Carbon by 2030 - Management Responses Paper was updated and circulated to Audit Committee for information.	**CJ**

07/2023 2.3.0	**Public Sector Readiness for Net Zero Carbon by 2030 - Management Responses Carl James to circulate the detailed Decarbonisation Plan to the Audit Committee outside of the meeting.**	**ACTION: Carl James**	**CLOSED** **September 2023:** The Trust Decarbonisation Plan was circulated to the Audit Committee.	**CJ**
07/2023 3.2.0	**Accountability Report for 2022-23 Governance Statement for Shared services and HTW were provided in draft format at the April 2023 Board Development Session. Emma to forward for completeness final copies to the Board and circulate to Audit Committee Members.**	**ACTION: Emma Stephens**	**CLOSED** **August 2023:** The report was forwarded and circulated for completeness.	**ES**
07/2023 3.2.0	**Accountability Report for 2022-23** • **Risk Register page 46 – In relation to the current rating and the target rating and the fact that sometimes they are substantially different, the later column to be removed.** • **Executive Directors section, the Committees they attend is to be corrected. For the Information Governance section detail around some of incidents and process, and ICO details need amending. Matthew Bunce will confirm these changes to Emma Stephens.** • **Appendix 2 page 74 - Director and Independent Members column champion roles are different to areas of expertise. Needs to be amended.** • **Internal Audit Section pages 54-57 reflect what is in the opinion so that it is consistent. The Committee agreed that there is not a need to go into in detail rather just reflect on**	**ACTION: Emma Stephens**	**CLOSED** **August 2023:** All actions noted in relation to the report have been completed.	**ES**

	the on limited assurance report and refer to the reports.			
07/2023 7.1.0	**Trust Risk Register** **Risk 3138 – The Committee questioned if this risk be in the public domain or private? Lauren Fear to look at the wording of this risk. A few dates in the date column are now in the past so this will be investigated.**	**ACTION: Lauren Fear**	**CLOSED** **September 2023:** This risk was removed from the papers. The risk is now a level 12 risk and not reportable to committees or Board.	**LF**
07/2023 7.2.0	**Governance Assurance & Risk Governance, Assurance & Risk Programme of Work** **Once the final version is ready this needs to be reviewed in the Steering Meeting with Gareth Jones as the Independent Member Lead and Nicola Williams as the Executive Lead and then it will be shared with the Audit Committee via email.**	**ACTION: Lauren Fear**	**CLOSED** **September 2023:** Shared following EMB Shape. On agenda for October 2023 Committee meeting.	**LF**
07/2023 7.3.0	**Review of Audit Action Tracker – Overdue and Completed Recommendations / Actions from Internal & External Audit** **The Committee agreed to task Matthew Bunce to ask Nicola Williams and Carl James to provide updates on their overdue actions outside of the meeting.**	**ACTION: Matthew Bunce**	**CLOSED** **September 2023:** Updates have been provided on the overdue actions and will be presented on the Audit Action Tracker Report for October 2023 Audit Committee.	**MB**
10.1.0	**Private Patient Service Debt Position** **Chris Moreton and David Osborne to assess whether the Corporate Finance Debtors Team has capacity to support the Private Patient Service in Debt Collection.**	**ACTION: Chris Moreton and David Osborne**	**CLOSED** **September 2023:** Priority task discussed with Financial Services and Accounting Manager to allocate resource and jointly remedy unallocated debt with Liaison.	**CM / DO**

10.2.0	**Losses and Special Payments Report: Gareth Jones raised the question in relation to the NHS England Debts are there are successor bodies to these organisations that have ceased to exist? Chris Moreton clarified he would need to check and assumed would have been picked up in the process of signing them off. Gareth Jones requested to not spend too much time on this.**	**ACTION: Chris Moreton**	**CLOSED** **September 2023:** When the organisations ceased operating, the Debt recovery Team and Trust Costing Accountant tried pursuing the debt with the newly established NHS England. They would not reimburse the costs on the basis that it was an issue between the Trust and the previous organisations. The debt was then transferred on to CCI Credit Management to recover. CCI confirmed that NHS England's legacy team would not make payment, as all balances owed to provider organisations had already been settled, in line with their Agreement of Balances process. Given that the Trust had exhausted all efforts to recover, it was considered no longer cost effective to further pursue these debts. Enhanced controls were then put in place within VCS to ensure permission/funding approval was sought from 'out of area' commissioning organisations, prior to treatment taking place.	**CM**

11.1.1	**Variation to Standing Orders Velindre University NHS Trust:** **Need to note the model and standing orders have now been caught up, to not ask for approval of the Non-Executive Director section twice as this was amended in April 2023.** **Page 8 new section vii first bullet to be changed to read "*ensuring NHS bodies and ministers think about the quality*" rather than "*NHS bodies and ministers to think about the quality*".** **Second bullet to be changed to "*honest with patients*" rather than "*honest with patents*".**	**ACTION: Lauren Fear**	**CLOSED** **September 2023:** Addressed Committees comments and final version shared with Trust Board.	**LF**
11.2.1	**Financial Control Procedure Update** • **FCP 1 – Budgetary Control procedure:** **Cover paper 2.1 to say last review undertaken December 2022 not December 2023.**	**ACTION: Matthew Bunce**	**CLOSED** **September 2023:** The Cover Paper has been updated on Admin Control and the website.	**MB**
11.3.3	**Trust Priorities:** **Recommendations / Agreed management actions. Specifically in relation to Page 11 of the report Matter Arising 2 Risks to Delivery – Finance and Resourcing. The Committee felt the agreed management action repeats the recommendation and doesn't say what the agreed action will be. The Committee requested more detail as to how going to deliver or meet the recommendations. To be addressed outside of meeting.**	**ACTION: Carl James**	**OPEN** **September 2023:** 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	**CJ**

			plan. The Executive Directors will produce a management plan and how we will implement the actions.	

AUDIT COMMITTEE

Private Patient Service Improvement Group Highlight Report

DATE OF MEETING	19th October 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	GARETH MITCHELL, DIRECTORATE SUPPORT OFFICER, CSMO
PRESENTED BY	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE
EXECUTIVE SPONSOR APPROVED	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE

REPORT PURPOSE	FOR DISCUSSION

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Private Patient Improvement Group	02/08/2023	Approved content
EMB	02/10/2023	Endorsed

ACRONYMS	
VUNHST	Velindre University NHS Trust

EMB	Executive Management Board
VCC	Velindre Cancer Centre
SLT	Senior Leadership Team
PPS	Private Patient Services

1. PURPOSE

This paper is for the Audit Committee to:

- **NOTE** the highlights from the Private Patient Improvement Group meeting held on the 2nd August 2023.
- **APPROVE** the amended Private Patient Improvement Plan action completion dates.
- **NOTE** the continuance of Liaison Financial Services external expert support for the areas identified in the improvement plan until the end October '23, however this support will likely need to be extended further given the absence of senior VCS management input into the service due to a number of vacancies and absences in the teams the private patient manager leads.

2. BACKGROUND

Following receipt of an External Private Patient review report identifying critical areas for improvement with the Velindre Cancer Centre's Private Patient service it was agreed by both the Executive Management Board and Audit Committee that a Private Patient Improvement Group would be established to drive through and oversee the required improvements.

The Executive Director of Nursing, AHP and Health Science was asked to provide Executive leadership to the Group and take on the role as Senior Responsible Officer (SRO). The role was accepted on the provision that appropriate delivery support would be allocated as identified by the SRO.

It was agreed that the Audit Committee would have oversight of the Finance and Commercial actions in the improvement plan and the Quality, Safety & Performance Committee oversight of all other actions i the improvement plan.

3. PRIVATE PATIENT IMPROVEMENT PLAN

The Private Patient Improvement Plan was reviewed at the 02/08/2023 Private Patient Improvement Group with an extended deadline given to the majority of actions. This gave most actions a new delivery date of 31/10/23.

4. HIGHLIGHT REPORT

The following are additional highlights from the meeting.

ALERT / ESCALATE	<u>BI support issues</u> There are continual issues accessing BI support due to pressures from DHCR and other key programmes. This is affecting the ability to produce performance information against a set of KPIs to enable performance to be monitored. In addition, there is a request for the ability to produce key information relating to automated billing (Healthcode system). Further clarification is required from BI in relation to the challenges associate with this and a meeting has been arranged to discuss further. <u>Healthcare at Home contract</u> A draft contract document was received from Sciensus but the assessment was that it required further review and support from procurement services. Work is taking place with Shared Services to clarify the contractual agreement that was agreed with Healthcare at Home. <u>Extension to delivery deadlines within the improvement plan</u> Due to a number of long-term periods of staff absence in the private patient team, work on the improvement plan actions have been slower than planned. As such, a number of deadlines have been revised.
ADVISE	• Due to critical absences within the Finance Team and Private Patient Services Team, there has been unfortunate delays to the implementing the improvement plan, necessitating an extension to key deadlines and contracted support provided by Liaison from the end of August ’23 to end October ‘23. Depending on

absences in the private patient team the external support may require further extension.

- The elements of the Improvement Plan for delivery by Liaison have been reviewed and the majority of actions assigned to them were agreed for delivery by 31/10/23.
- Liaison have advised that all the preparatory work has been completed for contract negotiations with the main Insurance providers. Based on this preparatory work their assessment is that the Trust should benefit from one-off additional income based on the retrospective review and letters and invoices sent to Insurers of **£487k** and **£558k** prospective additional income per annum based on the work around ensuring all activity is invoiced and review and update of the Trust prices.
- Liaison have also revised operational governance and processing, including updated policies, contracts, billing procedures, databases, insight and analysis.

- The Commercial & Financial actions concluded or in progress are:

  - Renegotiate the contracts with insurers – ***Preparatory work prior to negotiation of current insurer contracts is complete. This included reviewing current contract tariffs and services provided compared to invoicing as well as ensuring billing is up to date. Liaison are in the process of negotiating with the Insurers and anticipate this will be concluded during November.***
  - Develop new professional fee arrangements which provide consistency across disciplines – ***this work has not commenced due to prioritising provision of operational management and insurer contract re-negotiation.***
  - Develop a private patient tariff for both self-pay and insured private patients setting fees at commercial levels – ***work is complete reviewing the current fees and cost of services which has been compared to market intelligence around fees for cancer services in other NHS Private Patient services, leading to the retrospective review income requests to Insurers and anticipated increase recurrent income going forward.***
  - Developed a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure – ***Charging processes and billing methodologies have been enhanced, though not reflective of applying new tariff, application of the tariff has not commenced due to***

	prioritising provision of operational management and insurer contract re-negotiation. ➢ Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act – ***this work has not commenced due to prioritising provision of operational management and insurer contract re-negotiation.*** ➢ Increased private income through exploiting opportunities to expand the clinical scope of the private patient service, as highlighted by the potential retrospective and prospective additional income streams – ***the agreed private patient strategy approved by the Board was to stabalise the existing service and offering so this action to review opportunities to expand the scope of services is not being progressed currently.*** ➢ Procure or develop a private patient management system that will enable production of regular management information including a private patient activity report - ***PPMG agreed that current Trust systems appropriate to capture information.*** ➢ Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk – ***Practice policies have been reviewed and updated, these are presently being concluded for discussion with Clinicians, ensuring payment arrangements are reflective of managing the risk equitably.*** ➢ Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service – ***review of the Sciensus contract has been undertaken, but the assessment was that it required further review and support from procurement services. Work is taking place with Shared Services to clarify the contractual agreement that was agreed with Healthcare at Home.*** ➢ Retrospective review of last 2 years insurer income to identify if Trust can recover additional income for services provided – ***Liaison has completed their work reviewing income and patient data provided by Trust and written to the insurance providers setting out the Trust case for retrospective income it is due, with the estimated income of £487k.***
ASSURE	Leaflet/Welcome Pack

	Liaison colleagues have made further progress on the Private Patient leaflet, having met with Gloucestershire Hospital Teams to understand their offering and how this can inform VCC's offering. This is now in the final stages of being developed. The Trust Patient Engagement team are being consulted in relation to what is offered to NHS patients and Private Patients and how there may be a similar offering at Velindre. Clarification is being sought with the Welsh Language Commissioner on the bilingual nature of materials created.
INFORM	Aged Debt Through the use of a new version of the Healthcode system, approximately £750,000 of unallocated cash in the Debtors ledger has been identified as relating to private patient activity and allocated to invoices bringing a reduction in the aged debt from around £1,000,000 to £250,000.
APPENDICES	***1. Private Patient Improvement Plan***

Improvement Plan - Private Patient Service

Date Updated: 17/05/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Action Progress	Action Owner	Target Date	Revised Target Date
STRATEGIC BUSINESS MANAGEMENT							
PP17	**IN PROGRESS**	28.01.22	Renegotiate the contracts with large insurers	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December 2022. 21/12/2022 - Target date revised to reflect discusions with Liaison Services who are supporting the renegotiation. A target of 31/03/2023 will remain for the preparation work of reviewing current contracts, tarrifs and ensuring Trust billing is up to date. DPIA's will be completed. 18/04/23 - Finance and LIAISON working together on financial resoruce mapping 17/05/23 - Work ongoing but may stall without **DO.10/10/23 - Preparatory work prior to negotiation of current insurer contracts is complete. This included reviewing current contract tariffs and services provided compared to invoicing as well as ensuring billing is up to date. Liaison are in the process of negotiating with the Insurers and anticipate this will be concluded during November.**	COB/MB / External Provider	30/09/2022	30/11/2023
PP20	**IN PROGRESS**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	21/11/2022 - Tarrif will be updated in line with contract discussions as in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - Finance and LIAISON working together on financial resource mapping 17/05/23 - Work ongoing but may stall without DO. **10/10/23 - Practice policies have been reviewed and updated, these are presently being concluded for discussion with Clinicians, ensuring payment arrangements are reflective of managing the risk equitably. Application of new fees will be concluded following renegotiation of contracts.**	External provider	31/07/2022	30/11/2023
MEDICAL GOVERNANCE							
COMMERCIAL							
PP21	**COMPLETE**	28.01.22	Develop a private patient tariff for both self-pay and insured private patients	21/11/2022 - Refer to narrative in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 17/05/23 - Work ongoing but may be disrupted by BI resource issues. **10/10/23 - work is complete reviewing the current fees and cost of services which has been compared to market intelligence around fees for cancer services in other NHS Private Patient services, leading to the retrospective review income requests to Insurers and anticipated increase recurrent income going forward.**	External provider	31/07/2022	COMPLETE
PP22	**IN PROGRESS**	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - Revised processes have been established and are being rolled out. 17/05/23 - Work ongoing but may be disrupted by BI resource issues. **10/10/23 - Charging processes and billing methodologies have been enhanced, though not reflective of applying new tariff, application of the tariff has not commenced due to prioritising provision of operational management and insurer contract re-negotiation.**	External provider	31/07/2022	30/11/2023
PP25	**IN PROGRESS**	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	External provider 17/05/23 - Work ongoing but may be disrupted by BI resource issues. **10/10/23 - this work has not commenced due to prioritising provision of operational management and insurer contract re-negotiation**	External provider	31/07/2022	30/11/2023
OPERATIONAL							
PP43	**IN PROGRESS**	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - HCaH contract reviewed and maximised for Blood Testing, but not the wider Chemo service - all contract negotiations aligned to Q1 delivery. 17/05/23 - Issues to be worked up when DO returns. **10/10/23 review of the Sciensus contract has been undertaken, but the assessment was that it required further review and support from procurement services. Work is taking place with Shared Services to clarify the contractual agreement that was agreed with Healthcare at Home.**	PW	31/07/2022	31/10/2023
PP44	**IN PROGRESS**	07.06.23	To produce an output summary report at the conclusion of work conducted with the Trust, planned at Aug 23.	Liaison agreed to construction of output summary report **10/10/23 - extension of target dates reflected in delay to summary output.**	External Provider	31/08/2023	31/11/23

Definitions of 7 Levels Framework for Evaluating Delivery of Improvement Plans

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

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

TRUST RISK REGISTER

DATE OF MEETING	19.10.2023

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 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. • **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 – Run	31.08.2023
Quality, Safety and Performance Committee	14.09.2023
Trust Board	28.09.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The current position of the Risk Register was discussed and noted. In depth discussion took place in respect of risks 2465 and 2501 at the Executive Management Board. Following triangulation of information in respect of digital risk the Quality, Safety and Performance Committee were assured regarding the digital risk and the relation to legacy systems.	

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

3	Deep Dive Template

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 11 risks to report to Board and Committee on Datix 14, this includes 9 risks with a current score over 15 and 1 risk with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Risk Register

- The risk register detail in Appendix 1 is for noting by the Audit Committee. Due to timing of the reporting cycle, this is the same August extract as considered by the Trust Board in September. The October cut will be shared in Quality, Safety & Performance Committee and Trust Board in November.
- In respect of TCS risks; some are reported with expired review date, this is due to there being no governance cycle in August. Following the project meeting is risk will be updated on Datix.
- To note all actions in the Datix action plan section have assigned owners – however given named individuals on the system, this is not included in reporting. If any member would like further details, this can be provided.
- The Quality, Safety and Performance Committee and the Audit Committee requested the inclusion of a date by which the target rating will be received. Where information has been available this has been included manually for submission to the Trust Board on 28.09.2023. A decision has been made to include the target date as a substantive field on Datix, which will be reportable to Trust Board and Committees.

- There was substantial discussion at Trust Board on the risk register and there are a number of aspects which are being progressed during this reporting cycle:
    - Fundamentally the Board asked for further assurance on the proactive management of risks, as the current score on the highest rated risks has been static since the start of the monthly tracking.
    - Assurance needs to be provided to Board that risks with an impact of 5 are being appropriately reviewed and managed
    - Review risk title/risk in brief, as some are the same narrative
    - Review current controls and action plans, as some are the same narrative
    - Discussion on the scoring matrix and consideration to be given on how best to develop.

4.2 Risk In Depth Review

The Executive Management Board and Quality, Safety & Performance Committee discussed two risks, which have been open the longest to ensure effective plans ked to discuss risks open the longest, with a focus on the effectiveness of the action plans in place. This was then reported and discussed at Trust Board in September.

It was agreed that Audit Committee members who are not members of Quality, Safety & Performance Committee will be invited to the risk item in Quality, Safety & Performance Committee going forwards.

4.4 Next Steps in Engagement and Embedding

- The Datix 'How To' guide has been updated and can be accessed via the intranet: DATIX How To Guide
- Level 1 mandatory training for all staff has been live in individual ESR Learning Matrixes, as of 17th April 2023. Initial management of completion of training will be tracked via the Trust risk weekly meeting and reported into Executive Management Board.
- Regular reminders are shared in communications across the Trust to remind staff to complete the Introduction to Risk Training.
- As of 29th August 2023 an Introduction to Risk training has a completion rate of 66.8% across VCS, WBS and Corporate.

Compliance Area	Compliance Rate

Corporate	67.88%
Research Development and Innovation	67.3%
Transforming Cancer Services	54.1%
Velindre Cancer Centre	62.99%
Welsh Blood Service	73.91%

Compliant with statutory and mandatory training a period of six months is set for initial completion, the on-going requirement will be to complete the training every two years.

- As we approach the six month initial completion deadline work will be undertaken with managers to ensure completion of level one training.

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

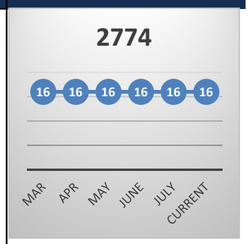
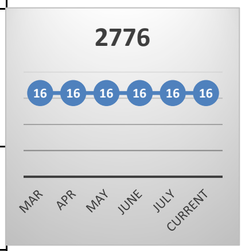
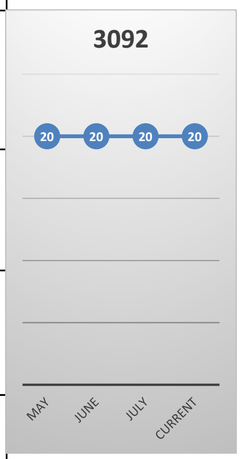
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require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

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

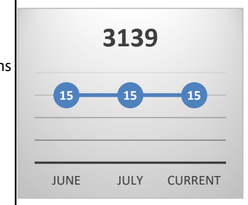
APPENDIX 1

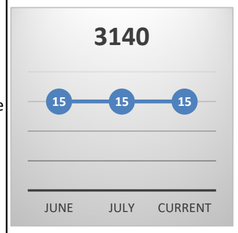
Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

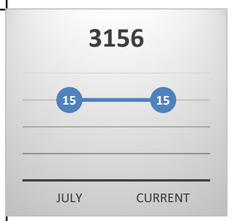
RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, 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

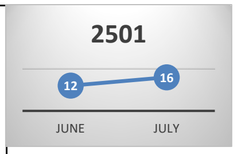
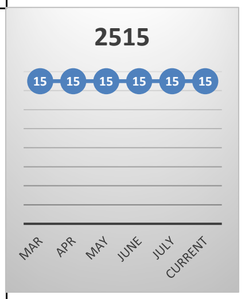
ID	Risk Title - New	Risk (in brief)	Risk Type	Opened	Amount of Days Open	Division	RR - Current Controls	Rating (initial)	Rating (current)	Rating (Target)	Date to Reach Target Rating	Review Date	Action Plan On target Overdue Complete		Risk Rating Trend
2774	There is a risk to Quality and Safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	Data entry/transcription errors introduced during overly complex manual workaround processes could potentially lead to issue of incorrect test results and clinical advice, which could impact patient safety. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Staff are required to check multiple spreadsheets to decide which tests need to be done. In an on call situation, a single member of staff is required to manually check information in multiple places. There are longer-term plans to implement a new system. Once implemented, the replacement system would mitigate this risk.	Quality	27/10/2022	312	Welsh Blood Service	Staff diligence - multiple manual checking stages prior to issue of results and associated clinical advice. Minimal updates progressed within constraints of the existing IT system.	20	20	4	31/03/2025	14/02/2023	31/07/2024	Complete actions for replacement LIMS - see risk 2776	
												29/09/2023	Tender for replacement IT System (Q2)		
												31/12/2025	Implement replacement IT System (Q3)		
2776	There is a risk to performance and service sustainability as a result of significantly limited IT expertise to support the ongoing use of outdated, legacy systems, leading to inability to provide core operational services.	Inability to provide core services could lead to patient harm for those requiring acute urgent services and reputational damage. Inability to enhance and develop new transplant services to meet business needs and/or other factors such as changes to external regulatory requirements. Transplant services are reliant on in-house developed IT applications built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. There are longer-term plans to implement a new system. Once implemented, the replacement system would mitigate this risk.	Performance and Service Sustainability	27/10/2022	312	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work needed to maintain the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT Subject Matter Expert resource. In the event of IT system failure, a business continuity agreement is in place. Core transplant services would be referred to NHS England.	16	16	4	31/03/2025	14/02/2023	28/04/2023	Secure Funding for replacement LIMS	
												29/09/2023	Tender for replacement for IT System		
												31/12/2025	Implement replacement for IT System		
												01/09/2023	Review Risk Assessment		
3092	there is a risk that patients may receive inappropriate management/treatment as a result of inaccurate manual data entry into WPAS/EIRRMER following implementation of DHCR leading to patients being allocated to an inappropriate treatment pathway/clinician.	there is a risk that patients may receive inappropriate management/treatment as a result of inaccurate manual data entry into WPAS/EIRRMER following implementation of DHCR leading to patients being allocated to an inappropriate treatment pathway/clinician.	Multipl Risk Domains	27/04/2023	130	Velindre Cancer Centre	- A series of deep dives to understand problem areas have been undertaken - Clear actions plans have been developed across directorates - An operational management group have been stood up to oversee delivery of actions and determine wider trends, reporting to the Business Planning Group (BPG) and Senior Leadership Team (SLT) - Refresher training being provided across VCC	20	20	8		31/07/2023	31/05/2023	Risk needs reviewing	
												07/06/2023	Risk needs reviewing		
												31/07/2023	use of WPAS		
												23/06/2023	Query why Chemocare is still part of this risk		

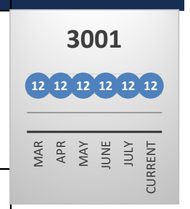
3139	Clearance Limitations There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	Performance and Service Sustainability	21/06/2023	75	Transforming Cancer Services	1) Application to be clear on expected plan for clearance works 2) Alternative plan should limitations be put in place 3) Sceure 3rd party opinion on clearance	12	15	6	15/09/2023	04/08/2023	04/08/2023	1) Application to be clear on expected plan for clearance works 2) Alternative plan should limitations be put in place 3) Secure 3rd party opinion on clearance
3140	EPSL Application Approval There is a risk that the EPSL application will not be approved or takes longer than planned to be approved by the NRW leading to delays to required clearance or miss the clearance window causing approx 6 month further delay.	There is a risk that the EPSL application will not be approved or takes longer than planned to be approved by the NRW leading to delays to required clearance or miss the clearance window causing approx 6 month further delay.	Performance and Service Sustainability	21/06/2023	75	Transforming Cancer Services	1) Resolution of habitat management matters to provide NRW with assurance they require 2) Respond to any queries as a matter of priority 3) Liaise with Cardiff Council to agree approach 4) Work with WG to intervene if required 5) Maintain Actions Tracker	12	15	6	16/10/2023	04/08/2023	04/08/2023	1) Resolution of habitat management matters to provide NRW with assurance they require 2) Respond to any queries as a matter of priority 3) Liaise with Cardiff Council to agree approach 4) Work with WG to intervene if required 5) Maintain Actions Tracker
3156	Transfer of new Equipment There is a risk that delay to opening of the nVCC will lead to the necessity of transferring new equipment which has been procured in the interim leading to greater operational disruption, prolonged commissioning period and costs.	There is a risk that delay to opening of the nVCC will lead to the necessity of transferring new equipment which has been procured in the interim leading to greater operational disruption, prolonged commissioning period and costs.		17/07/2023	49	Transforming Cancer Services	1) Determine impact and seek WG support for revised cash flow - ongoing	10	15	10		04/08/2023	No Action Plan	No Action Plan
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.	Safety	05/11/2021	668	Velindre Cancer Centre	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.	16	16	4	31/03/2024	29/12/2023	09/10/2023 30/06/2023 29/09/2023	Head of Information Governance (HOIG) has commenced the internal audit, as of 01.09.2023. Following areas have been interviewed: SACT Bookings SACT Preparation SACT Helpline Consultant Oncologist Following activity planned for week email etiquette to be developed as part of hybrid working tool kit and shared widely. To be closed pending All Wales email policy. Associated SOPS will need to be developed to reflect this updated policy. Development will be lead from a Trust level by Head of IG. Timelines - imminent. Reporting will be via QSMG and via EMB IB to undertake an audit into the use of email within the medical directorate and SACT booking meetings continuing to be undertaken. Progress delayed due to demands from COVID inquiry. completion date updated



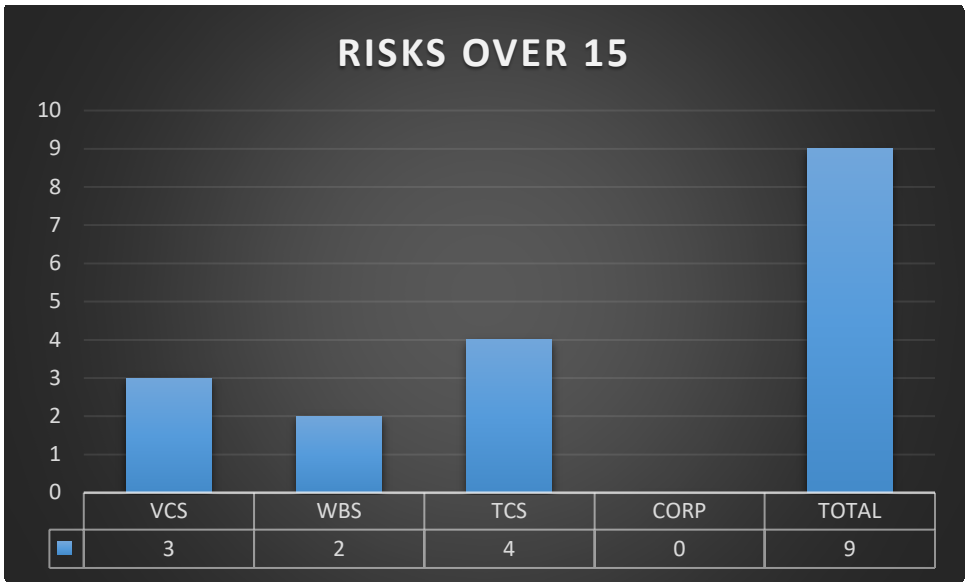




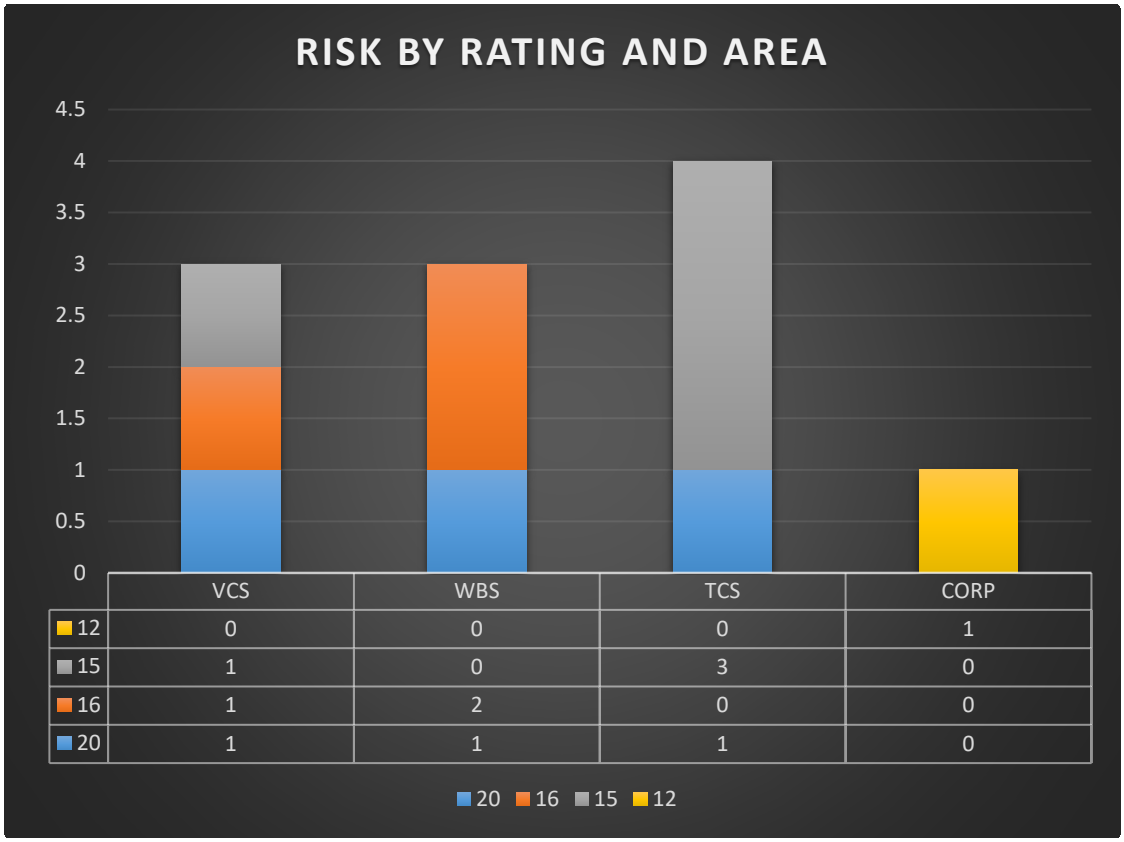
2501	Inflation - There is a risk that increased rates of inflation before financial close lead to the costs of the project exceeding the affordability envelope.	There is a risk that increased rates of inflation before financial close lead to the costs of the project exceeding the affordability envelope	Financial Sustainability	14/01/2022	598	Transforming Cancer Services	1. Discuss with Welsh Government. Increased CAPEX approved. Complete 2. Monitor inflation inline with the financial index. Ongoing	20	16	12		28/07/2023	No Action Plan	No Action Plan	
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.	Performance and Service Sustainability	09/02/2022	572	Velindre Cancer Centre	Service provision across all specialties 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	20	15	15		30/09/2023	30/09/2023 14/03/2023 28/03/2023 31/07/2023	Brachy Workforce The risk review is overdue A SMART Action Plan needs to be developed Insufficient brachy MPE	

ID	Risk Title - New	Risk (in brief)	Risk Type	Opened	Amount of Days Open	Division	RR - Current Controls	Rating (initial)	Rating (current)	Rating (Target)	Expected Date to Reach Target Rating	Review date	Action Plan On target Overdue Complete		Risk Rating Trend
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.	Safety	09/12/2022	269	Corporate Services	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	16	12	9	30/12/2026	31/12/2023	31/03/2024	Divisions/Departments should have proactive stress risk assessments	
													09/12/2022	Formal arrangements not in place for the Healthy and Engaged Steering Group to evaluate wellbeing interventions	
													21/03/2023	This risk needs a SMART action plan	
													22/12/2023	Systemic factors that impact on levels of workforce stress to be described and associated actions plans developed	
													31/03/2024	Develop management training in managing stress	

Data Graphs


RISKS OVER 15
10
9
8
7
6
5
4
3
2
1
0
VCS
WBS
TCS
CORP
TOTAL
3
2
4
0
9


SAFETY RISK RATING 12
1.2
1
0.8
0.6
0.4
0.2
0
VCS
WBS
TCS
CORP
TOTAL
Series1
0
0
0
1
1



	VCS	WBS	TCS	CORP
12	0	0	0	1
15	1	0	3	0
16	1	2	0	0
20	1	1	1	0

AUDIT COMMITTEE

Governance, Assurance and Risk Programmes of Work

DATE OF MEETING	19.10.2023
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	The report provides an update of the Governance, Assurance and Risk (GAR) Programme of work, detailing the status of individual parts of the programme and the overall status.
RECOMMENDATION / ACTIONS	The Audit Committee are asked to **DISCUSS** the update in respect of the GAR project and proposed approach to the next phase.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Shape	***18.09.2023***
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The GAR project was discussed and noted by the Executive Management Board.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

APPENDICES	
1	GAR Work Programme Overview
2	Progress of Programme Data

1. SITUATION

The 'Governance, Assurance and Risk' Programme of work was designed as a key programme within the 'Building our Future Together' programme and has been progressing since October 2022. In autumn 2022, the Executive Management Board discussed and agreed the scope and outcome objectives across the twenty projects. This was then agreed at the Audit Committee.

The programme of work was considered further by Executive Management Board, the Audit Committee and the Trust Board in May 2023. This was also context to the assessment of the Trust Board assessment of Board effectiveness for 2022-23 at this time.

2. BACKGROUND

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

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

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

The BOFT is a three year development programme. The GAR programme looks to progress within one year, the date parameters for the steering committee are aligned with the programme of work timeline.

3. ASSESSMENT

The update attached outlines the progress since autumn 2022 of the projects which make up the Programme.

The approach of the programme has been collaborative and distributed in terms of input and responsibilities.

Key examples of engagement across the work include:

- Supporting teams to embed risk and risk discussions in team meetings, as well as establish the importance of good, clear up to date information on Datix, including SMART action plans (RISK5.1.4).

- Significant time spent on paper writing training from key contributors (GOV4.1.1)

- A series of workshops were run for the launch of the Standard Committee highlight/assurance report format (GOV2.4), alongside a 'How to' guide to embed the use of the new template, which has been in use since the beginning of August 2023, ahead of the target date.

- The increased automation of the Trust Assurance Framework will be supported by engagement with teams to establish the refreshed template on the SharePoint system with ongoing engagement in corporate team meetings to ensure regular updates of the TAF are undertaken and updated (TAF3.1).

Executive Management Board were asked to consider the following particular areas, with the conclusions recommended for the Audit Committee to note are below:

- G1.1.2 and G1.2.1 regarding KPIs. Work has been underway however there are no other examples or benchmarks to learn from. There will be reporting against the milestones in the Governance Manual, Gov 3 project, from December 2023. It was proposed in latest Steering Group meeting that this is the initial priority and any further KPIs to be considered following further embedding, in April 2024. Executive Management Board agreed with this approach.

- G4.2.1 and Gov 5 project were discussed with Executive Management Board members. It was discussed that the revised Paper template provides the baseline for this work and the Board development programme to be developed to more clearly reflect this. It was agreed to complete this work in time to inform the 2023-24 Board Development framework.

- Gov 6 regrading Delegation frameworks was discussed with Executive Management Board members as to what else required following work by Finance on capital delegation framework. Links to Divisional governance comment below.

Next Phase

The next 6 months to end March 2023 will be used to complete all actions against the current scope in line with the timeframes on the attached tracker.

In addition the following actions considered and added to the scope for completion by March 2023:

- Divisional level governance
  - The work regarding training and support on the refreshed Governance module will provide an important step in Divisional level governance development
  - Audit Wales programme include a review in 2023-24 programme
  - Further input will be discussed with divisional teams as to what support corporate governance team can provide in this development
  - This to also include input from a clinical governance perspective (as per updated TAF strategic risk)

- Risk
  - Discussion with EMB and Risk teams as to proposed progression of embedding
  - Proposed level 3 by December 2023 and level 4 by March 2024
  - Level 5 then later in 2023/24

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

- Learnings from recent national significant issues, which had not occurred prior to previous GAR scope being agreed.
  - Triangulation of learnings from national issues and reviews (including Betsi Cadwaladr and Chester)

- GAR can form approach to structure actions (where in GAR scope) agreed by the Trust Board for these respects.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Audit Committee are asked to consider and **DISCUSS** the work so far with the GAR Project, including the detailed update (Appendix 1).

Additionally, The Audit Committee are asked to **DISCUSS** the next steps detailed in 3.0 of this report.

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*	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 this work spans 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 yet completed (Include further detail below why)
	There are no socio economic impacts linked directly to the paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	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	No
WHAT IS THE RISK?	No specific related risks, although the work in this paper links to strategic risks, detailed in the Trust Assurance Framework and the management of risk across the Trust
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
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	

	Task Name	OUTPUTS	DATE DUE FOR COMPLETION	STATUS	UPDATE
GOV #1 STRUCTURE		**Oct-23**			
G1.1	**Board Structure**				
G1.1.1	Take forward and implement all internal and external audit actions relating to Governance, Assurance and Risk development.	Confirm that all of the external and internal audit actions are incorporated in the GAR programme scope.		Complete	Mapping exercise complete to establish clear view of internal and external audit actions.
		Complete all actions relating to external and internal audit.		Complete	Please refer to GAR related action:
G1.1.2	Identify KPIs to assess the effectiveness and benefits of new committee structure.	KPIs to assess and monitor benefits realisation of new committee structure		On target	A benchmarking review has been undertaken resulting in no comparisons identified. Input has been sought from Shared services Audit and Audit Wales for independent view. IM views and Exec views, will be sought informally and will brought back in October. A six month review will take place in April 2024.
G1.1.3	Review sub Committee reporting lines to ensure no risk of duplication or gaps in reporting.	Confirmation through review of agenda and cycle of business		Complete	The outcome of this exercise will be fed into the Board Development session in June 2023.
G1.2	**Executive Level Governance**				

G1.2.1	Develop and agree KPIs in support of GAR G1.1.2	KPIs to assess and monitor effectiveness of Executive level governance		On target	A benchmarking review has been undertaken resulting in no comparisons identified. Input has been sought from Shared services Audit and Audit Wales for independent view. IM views and Exec views, will be sought informally and will brought back in October. A six month review will take place in April 2024.
G1.2.2	Effective implementation of ways of working approach for Corporate and Divisional Governance layer	Implementation of BOFT Deliverable 10 (Ways of Working)		Complete	New structure implemented as at May 2023. Following three months of operating July EMB Shape agreed that a further review of Velindre Futures, WBS Futures, Strategic Capital Board would be brought to September EMB and October Scrutiny Committee.
G1.3	**Link to whole organisational governance**				
G1.3.1	Effective implementation of clear principles and guidance around organisational governance, as set out within the Corporate Governance Manual.	Clear principles and guidance around organisational governance	Oct-23	On target	A comprehensive review of the Corporate Governance Manual has been initiated and will encompass all of the key Corporate Governance aspects required.
G1.3.2	Ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines	Compare outputs of divisional map of meeting reporting structures with an established view of what reporting is required to corporate layer		Complete	A collaborative review has been undertaken across the Trust to identify which meetings consider Quality and Safety matters and their associated reporting lines via the Integrated Quality and Safety Group.
G1.3.3	Review and establish clear alignment of reporting timelines and requirements into Corporate Governance layer.	Corporate Meeting Schedule April 2023-March 2024.		Complete	Board and Committee schedule has been developed incorporating key dependencies across the Corporate Governance layer, including flow from Divisions to appropriate Committees and Board, as required. Tracking document maintained to ensure any amendments throughout the reporting year are captured. To note, this action is closed, however further work is progressing.
G1.4	**Clinical Governance**				
G1.4.1	Establish clear roles and responsibilities for Assistant Medical Director within Committee level governance.	AMD Job descriptions to incorporate Board Committee roles and responsibilities.	Oct-23	On target	

G1.4.2	Agree and determine the Trust approach to adopting the organisational level best practice with support from the Faculty of Medical Leadership Management, including agreeing the mechanism for how this will be delivered.	Agreed programme of work with FMLM for organisational layer	Oct-23	On target	The MOU is signed with FMLM (led by Jacinta Abraham) . FMLM supported the medical engagement event in March 2023 (led by Jacinta Abraham) Exec development session with FMLM to be scheduled to agree approach going forwards.
GOV #2 PROCESS & TEMPLATES			**Oct-23**		
G2.1	Meetings: Standard agenda format.	A standard approach and process to agenda format and structure across the Trust Board/Committee meeting arrangements e.g. use of consent agenda, categories for 'noting', 'discussion and review', 'Endorsement' and 'approval'. Core governance subjects are included across the divisional meeting arrangements.		Complete	A review of the agenda format has been undertaken. A number of key principles have been agreed for adoption in terms of the use of the consent agenda and its agenda position to ensure discussion is focused on the key matters of business at each meeting. The development of the new reporting template encompasses a number of key principles for considerations, around Governance route, assurance rating, impact assessment, strategic goals, risk (strategic and operational), quality and safety, socioeconomic duty, wellbeing goals, financial, equality and legal impact.
G2.2	Meetings: Standard minutes format	A consistent format and house style for minutes across Trust Board, Committee and Divisional meetings.	Oct-23	On target	Formal minute training, externally facilitated, has taken place for key Board and Committee secretariat. The Chair of each of the Trust Board Committees together with the Executive Management Team to agree standard key principles and style to be adopted across the Board Committee structure by the end of June 2023 via the Board Development/ Briefing session.
G2.3	Meetings: Standard action log format	A consistent format and process for action logs across Trust Board, Committee and Divisional meetings.	Oct-23	On target	As per update ref. G2.2 once the principles of the standard minutes format has been agreed then follows the format of the standard action log.
G2.4	Meetings: Standard Committee highlight/assurance report format	1. A consistent format to the structure of highlight/assurance reports across Trust Board and Committees.	Oct-23	On target	As per update ref G2.2 and G2.3 Once the principles of the standard minutes and action log format has been agreed then follows the format of the standard committee highlight/assurance report format.

		2.Highlight reports will feed into the hierarchy of the Corporate Governance reporting structure.			
G2.5	Meetings: Standard cycle of business format	1. All aspects of the Terms of Reference will be captured in the cycle of business across divisions, Committees and Trust Board. 2. Ownership and accountability across all levels of the Trust. 3. Divisional senior meetings have clear cycles of business.		Complete	A clear flow through of business has been planned across Divisions, Committees and Board to reflect the Corporate Governance reporting cycle in the 2023-2024 Corporate Meeting Schedule. This has been shared both internally with key individuals in Divisions, Corporate functions and Board members, and also with Internal Audit and Audit Wales. Cycles of Business for Board and Committees to be disseminated with Divisions following each review and approval at EMB on a continual basis by each of the Divisional Directors.
G2.6	Meetings: Standard Board and Committee cover report template.	A consistent format to the structure of paper templates across Trust Board and Committees with clear guidance for completion.		Complete	The revised Cover report template has been completed together with a supporting 'How to' guide for review and approval at the April Steering Group with a view to roll out through the May 2023 reporting cycle onwards adopting a PDSA approach.
G2.7	A review of the Corporate Governance Manual in line with the refreshed processes and templates.	Corporate Governance manual will be reviewed and refreshed to include full suite of revised and new Corporate Governance documentation.	Oct-23	On target	A comprehensive review of the Corporate Governance Manual has been initiated and will encompass all of the key Corporate Governance aspects required.
GOV #3 COMPLIANCE & CORE PROCESS			**Dec-23**		
G3.1	Training for key roles in Divisions and Corporate functions in relation to the refreshed Corporate Governance Manual.	Completion of the training plan.	Dec-23	On target	Development of a plan to ensure training is rolled out to key individuals in Divisions and Corporate functions during August to October 2023.
G3.2	Embedding use of Board and Committee process flow chart planning tool	Consistent use of flow chart planning tool.	Dec-23	On target	Flow chart planning tool has been rolled out to the Board and Committee secretariat and a review cycle plan has been formulated.
G3.3	Tracking of compliance in the use of Board Committee process flow chart planning tool.	Reporting of compliance.	Dec-23	On target	Since roll out of the planning tool there has been informal reporting. Formal reporting will commence following the review cycle plan.
GOV #4 TRAINING & DEVELOPMENT			**Oct-23**		
4.1	**Staff**				

G4.1.1	Board and Committee report writing training.	Formal report writing training delivered by an external trainer		complete	Report writing training was provided across the Trust (23.09.2022) where each report author has been trained to agree with the report sponsor once commissioned to prepare a report for a Committee meeting to agree a report brief for each report to be received. This process will ensure that the report sponsor communicates with the report author what the purpose of the required report is and the details that need to be captured for the intended audience. Each Executive Lead for the respective report is required to formally approve each report for submission to the Committee and is accountable for ensuring that the purpose of the report is accurately reflected in each report.
G4.1.2	Induction training	Refreshed Corporate Governance training	Dec-23	On target	Refreshed Corporate training led by Workforce and OD was discussed at EMB in July including Corporate Governance input
4.2	**Board Members**				
G4.2.1	Board Development programme	Development programme agendas to take into account strategic matters which the Board has a formal obligation to consider e.g. WBFGA, Quality Act	Nov-23	On target	LF and ES to draft initial view to share with EMB Shape November 2023 (as per action 5.1). To then discuss and agree in IM Meeting.
G4.2.3	Independent Members: IM Champion Annual reports	Annual report from each Independent Member Champion Role.		Complete	
G4.2.4	Effective 15 Step visits programme implemented.	Independent Members will participate in two 15 Step visit events per year. Programme scope increased to include champion areas and corporate functions.	tbc	On target	To discuss next steps with NW
4.3	**Governance Team and wider governance related roles**				
G4.3.1	Formal minute taking training	Key Board and Committee secretariat formally trained in minute taking		Complete	Formal minute training, externally facilitated, has taken place for key Board and Committee secretariat.
G4.3.2	Development of induction for new starters and refresher training for existing team members in the Corporate Governance Team.	Corporate Governance training programme for new team members and refresher training for existing team members.	Dec-23	On target	Following the standardisation of standard processes and templates, as set out in G2, and the refresh of the Corporate Governance Manual, as set out in G2.7, and wider G2 aspects this work will commence.
GOV #5 BOARD DECISION MAKING			**Apr-24**		

G5.1	Mapping of decision making responsibilities	Compile matrix of Strategic matters which the Board has a formal obligation to consider e.g. WBFGA, Quality Act	Nov-23	On target	LF and ES to draft initial view to share with EMB Shape November 2023 (as per action 5.1). To then discuss and agree in IM Meeting.
G5.2	Embedding into decision making – culture and Evidence	KPI (line 8) will include the quality of how the paper template is used	Apr-23	On target	A six month review will take place in April 2024.
GOV #6 DELEGATION FRAMEWORK			**Oct-23**		
G6.1	Update to Delegation Framework for Trust	Approved updated Framework		Tbd	
G6.2		Any further update required between Executive and Divisional Governance		Tbd	
GOV #7 ASSURANCE THROUGH GOVERNANCE DEVELOPMENT			**Oct-23**		
G7.1	Implement the 7 levels of assurance as part of the establishment and functioning of the integrated Quality & safety Group making recommendations for the wider implementation.	7 levels of assurance approach adopted across the Trust		Complete	Workshops held with Service Leads across the Trust to support effective implementation of the 7 levels of assurance.
GOV #8 HOSTED ORGANISATIONS EFFECTIVE GOVERNANCE ARRANGEMENTS			**Dec-23**		
G8.1	NWSSP agreed plan – including hosting agreement	Refreshed hosted agreement		Complete	Agreement with Shared Services regarding effective reporting and governance arrangements to Quality, Safety and Performance Committee. This will be reviewed on a continual basis to ensure effective reporting is established.
G8.2	HTW agreed plan – including hosting agreement	Refreshed hosted agreement	Dec-23	On target	Revised agreement currently being costed by Finance colleagues. Discussions initiated with Health Technology Wales to review effective reporting and governance arrangements.
GOV #9 INNOVATION			**Dec-23**		
9.1	**Innovation**				
G9.1.1	BOFT approach to Governance	The product of BOFT approach principles will be shared with peers for learning.	Dec-23	On target	Introduced to peer group and agreed for future agenda

9.2	**Looking outwards**				
G9.2.1	In one year, two examples of best practice	Examples of best practice identified, learning undertaken and insight feedback into the organisation.	Dec-23	On target	
G9.2.2	Desktop review every other month with at least 1 examples – King's Fund, Nuffield, linked in agility etc.	1 ..Programme of review in place. Feedback shared following reviews	Dec-23	On target	
GOV #10 BOARD COMMITTEE EFFECTIVENESS			**Oct-23**		
G10.1	11 BOFT Programmes of work to be reported via EMB (Shape) Transformation Board and Strategic Development Committee	Tracking and monitoring of progress at EMB Shape and Strategic Development Committee	Oct-23	On target	BOFT PID approved at Trust Board on 30/03/2023 Regular Programme Highlight reports submitted to EMB Shape and Strategic Development Committee from April 2023 onwards, to track progress and delivery of the programmes of work.
RISK #1 RISK POLICY AND CORPORATE PROCEDURE			**Dec-23**		
R1.1	Develop risk policy	Risk policy will be developed then approved via governance cycle		Complete	The Risk Policy has been developed and approved. The policy is available on the intranet
R1.2	Develop risk procedure	Risk procedure will be developed then approved via governance cycle		Complete	Risk procedure refreshed, approved and is now available on the intranet
R1.3	Make policy and procedure available on intranet	Policy and procedure will be uploaded to the intranet		Complete	Both the Risk Policy and the procedure are available on the intranet
RISK #2 REFRESH RISK APPETITE			**Mar-23**		
R2.1	Review Trust Risk Appetite.	Refreshed risk appetite approved by the board and communicated through governance layers		Complete	Risk appetite has been reviewed, revised and approved via EMB and the committee cycle through to Board. Changes have been communicated through governance layers.
RISK #3 RISK REPORTING THROUGH GOVERNANCE			**Oct-23**		
R3.1	Risks reporting embedded in the Corporate Governance cycle.	Consistent report style and governance pathway for risk register through SLT/SMT, EMB, Committees and Trust Board		Complete	Risks are discussed at SLT/SMT through to EMB and Trust Board. The report style starts with EMB and is updated at each stage with discussions and suggestions at each stage of the governance process via the same report ensuring a consistent style.

R3.2	Guidance for groups to review risks within the scope of the group and reflect back to Datix	Clear principles and guidance around Risk management in place.		Complete	Ongoing discussion at regular Risk Team meetings regarding further embedding and feedback through representatives from each area of business. Support and guidance continues in respect of updating Datix regularly to reflect the current picture for risks.
RISK #4 ESTABLISHMENT OF RISK MANAGEMENT ASSURANCE GOVERNANCE			**Oct-23**		
4.1	**Operational**				
R4.1.1	Functional regular Risk Team Meetings established.	Terms of Reference established for the group.	Oct-23	On target	TOR is in development
		Regular meetings established.		Complete	Regular meetings have been established for over 12 months. The meeting is attended by representatives from VCS, WBS, TCS and Corporate. This group discusses current risks reportable to Board and Committees as well as the core risk business, including the ongoing development of a set of principles and a risk management culture, providing guidance and support through the organisation.
RISK #5 QUALITY INFORMATION ON DATIX			**Nov-23**		
R5.1.1	Risk Titles consistent on Datix.	Risk titles on Datix will follow guidance in order to fully capture the risk and impact.		Complete	There is also ongoing management of risk titles in divisions, supported by the Risk Team. The Risk title section on Datix has been altered to include clear guidance on information to be included on a risk title.
R5.1.2		Guidance and support available to ensure quality data is stored and maintained on Datix.		Complete	Training has been delivered to level 2 users who are responsible for managing risks. The training included information on risk titles, including core information to be included to produce a succinct and relevant title. Regular reviews are undertaken at various stages; team, SLT, Risk Team, EMB and committees.
R5.1.3	Retrospective cleansing of information stored on Datix	Quality data will be stored on Datix		Complete	Detailed work undertaken and measurement via levels of assurance going forwards regarding on-going improvement
R5.1.4	Inclusion of SMART actions onto Datix	SMART actions will be included for every risk on Datix	Dec-23	On target	There has been development of SMART actions, although there is still some way to SMART action plans being in place for all risks. Measurement via level 2 to 3 as first year objective. 1-2 improvement agreed at QSP, Audit Committee and Trust Board in July 2023.

5.2	**Identify risks not currently recorded on Datix and transfer to Datix**				
R5.2.1	Charity risks transferred to Datix	Charity risks will be recorded onto Datix	Dec-23	On target	Preliminary work undertaken with Charity Director; proformas supplied and support offered to facilitate the transfer of risk data to Datix. Continued work with the fundraising team has been undertaken during the period of time where there has been a gap in the Charity Director post. New potholder started 1.9.2023 so liaison will now take place to identify all charity risks.
R5.2.2	Research, Development and Innovation risks transferred to Datix	RD&I risks will be recorded onto Datix.		Complete	Collaborative work with the RD&I team resulted in all RD&I risks now being stored on Datix and reported from Datix.
R5.2.3	Risks not stored on Datix in Velindre Cancer Service identified.	VCS risks identified and transferred to Datix		Complete	An audit was carried out to ascertain where risks are held at VCS but not stored on Datix and issues addressed.
RISK #6 TRAINING			**Mar-23**		
	Complete and embed risk training across the organisation				
R6.1	Online Level 1 Risk Training: all staff.	Level 1 training available to all staff. A clear training pathway for new starters and refresher training on a 2 yearly cycle.		Complete	Level 1 training is now included in all staff learning areas on ESR for completion within six months. Two year cycle of renewal established for level 1 training. Initial compliance review plan established.
R6.2	Level 2 Risk Training: management level users	Level 2 users have undertaken relevant training for managing risks		Complete	Level 2 training delivered via virtual classroom to enable users to understanding of writing, assessing and managing risk as risk owners/leads.
R6.3	Level 3 Risk Training: Exec and Board			Complete	Level 3 training delivered to Board members and Execs via Board Development session.
TAF #1 ALIGNMENT OF FRAMEWORKS			**Nov-23**		
T1.	**Risk Framework**				
T1.1	First line of defence aligned and mapped with key Trust wide frameworks: Risk Framework	Alignment with Risk Framework		Complete	New template agreed
T1.2	Align risks over 15, by domain, to strategic risks on TAF	Domains identified for strategic risks		Complete	Risk Domains for each strategic risk is now included in the Trust Assurance Framework Dashboard.
T1.3	Identify trends in strategic risks	Established reporting mechanism to identify relevant trends.		Complete	The refresh of the Trust Assurance Dashboard now enables the tracking of risk levels over a period of time to identify trends as they emerge. No specific trends have emerged to date.

T1.4	Review risks under the TAF for scrutiny and assurance	Regular review cycle of risks established		Complete	New TAF template has been developed and includes risks from Datix under each strategic risk. New template will be used from April 2023
T1.5	Establish a mechanism to feed discussion regarding TAF	Regular review and discussion established	Nov-23	On target	Discussion takes place within teams, at committees and in catch ups with Execs. Corporate team meetings now considering. Need to ensure embedded at Divisional level
T2	**Performance Framework**				
	First line of defence aligned and mapped with key Trust wide frameworks: Performance Management Framework.	Alignment with Performance Management Framework.	Nov-23	On target	To be completed on new template (action T1.1)
T3	**Quality and Safety Management Framework**				
	First line of defence aligned and mapped with key Trust wide frameworks: Quality and Safety Management	Alignment with Quality and Safety Management Framework	Nov-23	On target	To be completed on new template (action T1.1)
TAF #2 REFRESH OF TRUST ASSURANCE FRAMEWORK RISKS		**Oct-23**			
T2.1	Review strategic risks	Refreshed strategic risks aligned with the refresh of the Trust risk appetite.		On target	Collaboration with VCS and WBS leadership teams, shaping session in Strategic Development Committee and EMB have taken place. Final shaping session with SDC on 04.09.2023 , QSP review 14.09.23 and proposed for Trust Board approval 28.09.23.
T2.2	Link to strategy			On target	As above
T2.3	Link to audit tracker	Link to Audit tracker, including actions and progress to complete, linked to assurance levels.			
T2.4	Map horizon scanning				
TAF #3 REVISED REPORTING MECHANISM		**Oct-23**			
T3.1	Increased automation of Trust Assurance Framework	Semi-automated system in place to aid monthly review cycle for the Trust Assurance Framework.		On target	The system is set up ready for use, this will now be on SharePoint. Reporting functionality is being further reviewed by IT colleagues. Following approval of Strategic Risks refresh the new template will be populated.
		Implementation of new automated dashboard to report and monitor progress against the Trust principle risks.		On target	IT are supporting with Power BI. Testing phase for preliminary automation completed. Following strategic risk refresh system will be populated

T3.2	Power Business Intelligence for reporting against TAF	Power BI will support the TAF Dashboard		Complete	IT are supporting with Power BI. This work will continue until automation of TAF is embedded. Following collaboration with Digital colleagues it was suggested that the most efficient and accessible way to manage the new template is via Share Point
T3.3	Explore external resource and support with assistance of Audit Wales			Complete	Following collaboration Audit Wales confirmed they were not in a position to offer Power BI support at this time. Trust IT team are now supporting Power BI work.
T3.4	Relevant Trust Assurance Framework data and Trust Risk Register included at all relevant meetings, demonstrating where key risks are addressed during the meeting.	TAF and TRR will be discussed at all relevant meetings		Complete	Trust Assurance Framework goes to committees: Executive Management Board - Shape, Strategic Development Committee, Audit Committee and Trust Board receive the complete TAF. The Quality Safety and Performance Committee receives relevant TAF risks. Trust Risk Register is considered at Executive Management Board - Run, Quality, Safety and Performance Committee, Audit Committee and Trust Board.
TAF #4 MAPPING OF TAF THROUGH THE GOVERNANCE CYCLE			**Oct-23**		
T4.1	Cycles of Business for each relevant committee to provide appropriate consideration of each of the Trust Assurance Framework controls and sources of assurance.	At each level of the Trust governance, cycles of business review and scrutinise the identified TAF controls and sources of assurance.		Complete	TAF or relevant cut of TAF is now included in EMB, QSP, SDC, Audit and Trust Board. Confirmed TAF is included in cycles of business for committees.
T4.2	Mapping relevant actions into governance cycles	Agreed actions for each of the TAF risks, controls and sources of assurance are regularly reported and monitored across the entire breadth and scope of Trust Corporate Governance.		Complete	TAF or relevant cut of TAF is now included in EMB, QSP, SDC, Audit and Trust Board
T4.3	Committees to scrutinise progress to address gaps in controls and assurance	At each Trust Board and Committees where the TAF is received scrutiny applied to address gaps in controls and assurance.		Complete	Discussion and review is now taking place at team level address gaps in controls and assurance. The Quality, Safety and Performance Committee reviews any gaps in controls and assurance via the QSP TAF extract.

AUDIT COMMITTEE

AUDIT REPORT RECOMMENDATIONS ACTIONS

DATE OF MEETING	19/10/2023
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	Matthew Bunce, Executive 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** the 25 Internal Audit (59%) and 1 External Audit (25%) Audit Report actions have been completed since the July '23 Audit Committee **(Green Status)**. If approved these actions will be formally Closed **(Blue Status).** • 6 Internal Audit (14%) and 2 External Audit (50%) actions have passed the agreed implementation date **(Red Status)** and extension dates are requested by the Executive / Director lead. The Audit Committee is asked to **APPROVE** the extension dates identified. • The Audit Committee are asked to **NOTE** the actions that are on target for completion by agreed date **(Yellow Status)**.

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 with the 'July 2023 updates' 31 July 2023 and 'August 2023' updates 31 August 2023. This 'September 2023 Updates' Report was taken to 02 October 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 **NOTED** the Recommendations / Actions provided in the report.	02/10/2023
	(DD/MM/YYYY)
	(DD/MM/YYYY)
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 October 2023
Appendix 2	Audit Action Tracker – Updated September 2023 – 19 October 2023 Audit Committee

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 July '23 Audit Committee during July '23 and August '23 further updates from Action owners on implementation progress were sought. Responses have been added to the 'September 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 all 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 November 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
September	18 September 2023	02 October 2023	05 October 2023 (Re-arranged since to 19 October 2023)
October	16 October 2023	30 October 2023	
November	20 November 2023	04 December 2023	19 December 2023

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 2 Internal audit reports were added to the Audit Action Tracker following the July '23 Audit Committee which included 8 Matters' arising with 10 recommendations, of which 5 were medium priority, 5 low priority and 0 high priority. In response to these Internal Audit recommendations management identified 10 actions. The 2 reports added were:

- Follow Up: Previous Recommendations – Draft Internal Audit Report
- Trust Priorities – Final Internal Audit Report

2.2.2 Work undertaken by Management / Officer leads to complete actions since the July '23 Audit Committee has resulted in 25 Internal Audit actions being completed.

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

Internal Audit Report Actions					
	TOTAL ACTIONS	**HIGH**	**MEDIUM**	**LOW**	**N/A**
July '23 Audit Committee					
Total Outstanding Actions	56	2	29	25	0
Less: Completed Actions (Green) – Agreed by Audit Committee to close (Changed to Blue)	(24)	(2)	(14)	(8)	0
Following July '23 Audit Committee					
Total Outstanding Actions	32	0	15	17	**0**
Add: Total Actions from new reports presented by Internal Audit to July '23 Committee	10	0	5	5	**0**
Total Outstanding Actions	**42**	**0**	**20**	**22**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 31 July '23 (Update July 2023)	17	0	7	10	0
Total Completed Actions (Green) – propose close (Blue) @ 31 August '23 (Update August 2023)	5	0	4	1	0
Total Completed Actions (Green) – propose close (Blue) @ 19 October '23 (Update September 2023)	3	0	2	1	0
Total Completed Actions – propose close (Blue)	**25**	**0**	**13**	**12**	**0**
Total Outstanding Actions @ 19 October '23 (excludes completed actions)	**17**	**0**	**7**	**10**	**0**

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

September '23 – Internal Audit

Priority	2022/23	2023/24	Total
No. of Audit Reports	21	6	**27**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	20	22	**42**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete July 2023	Action complete August 2023	Action complete August 2023	Closed
High	0							10
Medium	20	3		4	7	4	2	95
Low	22	3		7	10	1	1	59
N/A (Advisory Audit)	0							10
Total Open Actions	**42**	**6**	**0**	**11**	**17**	**5**	**3**	174
% Open Actions	**100%**	**14%**	**0%**	**26%**	**40%**	**12%**	**7%**	**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 June 2023	Action complete August 2023	Action complete September 2023	Closed
Executive Director of Finance	11	2			6	2	1	55
Director of Strategic Transformation, Planning & Digital	18	1		6	9		2	19
Director of Governance & Chief of Staff	2			2				20
Director of Nursing, AHPs & Health Science	4				1	3		4
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	4	2		1	1			8
Director of Strategic Transformation, Planning & Digital and Executive Director of Finance	2			2				
Total	**42**	**6**	**0**	**11**	**17**	**5**	**3**	**174**

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

Priority	2022/23	2023/24	Total
High			
Medium	3		3
Low	1	2	3
N/A (Advisory Audit)			
Total	4	2	6

2.2.5 There are 6 actions (14%) for which the implementation date has passed and management action is not complete (Red).

2.2.6 There are 25 actions (59%) since the July '23 Audit Committee that have been completed.

2.2.7 There are 11 actions (26%) 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 No External audit reports were added to the Audit Action Tracker following the July '23 Audit Committee.

2.3.2 Management / Officer leads have completed 1 further action since the July '23 Audit Committee.

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

September '23 – External Audit

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

Priority	2022/23	2023/24	Total
No. of Audit Reports	6	1	**7**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	1	3	**4**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete July 2023	Action complete August 2023	Action complete September 2023	Closed
High	3	2		1				9
Medium	0							3
Low	0							2
N/A (Advisory Audit)	1						1	34
Total	**4**	**2**	**0**	**1**	0	0	1	**48**
%	**100%**	**50%**	**0%**	**25%**	**0%**	**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 July 2023	Action complete July 2023	Action complete July 2023	Closed
Executive Director of Finance	0							10
Director of Strategic Transformation , Planning &	3	2		1				4
Director of Governance & Chief of Staff	0							20
Director of Nursing, AHPs & Health Science	1						1	1
Director of OD and Workforce	0							9
Chief Operating Officer	0							2
Director Corporate Governance & Chief of Staff & Executive Director Nursing, AHP and Health Science.	0							2
Total	**4**	**2**	**0**	**1**	**0**	**0**	**1**	**48**

2.3.4 There are 2 actions (50%) for which the implementation date has passed and management action is not complete (Red).

2.3.5 There is 1 action (25%) since the July '23 Audit Committee that have been completed.

2.3.6 There is 1 action (25%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.4 Summary of the position as of 19 October 2023:

- 25 (59%) Internal Audit Report actions and 1 (25%) External Audit Report action have been completed **(Green Status)** which are requested to be closed (Blue Status).

- 11 (26%) Internal Audit Report actions and 1 (25%) External Audit Report actions are on target for completion by the agreed date **(Yellow Status).**

- 6 (14%) Internal Audit Report actions and 2 (50%) External Audit Report actions that have passed their agreed implementation date (**Red Status**) for which extensions to completion dates are requested.

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**
	Select all relevant domains below

QUALITY AND SAFETY IMPLICATIONS / IMPACT	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*
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.

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter arising 4	4.2 b. The Audit Committee should approve the updated FCP.	Medium	4.2 b. The recommendation is accepted. The updated FCP will be endorsed at the Capital Planning Group for approval by the Audit Committee. .	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	31/05/2022 November 2022 out of Commiteee Extension agreed: 26 January 2023. Extension Request agreed in April 2023 Audit Committee: 31 July 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 has been scheduled for the beginning of Sep to review the procedure following significant changes following the Establishment of SCB. **Request for further extension to end of December**	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 updated implementation date. A meeting of key personnel met at the Start of Sep with a further meeting scheduled for wc18th September to udpate and review the procedure following significant changes following the Establishment of SCB.	31 December 2023	19 months	3	

Charitable Funds 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matther arising 1	Matter arising 1: Charitable Funds Policies (Design) 1.1 Management should ensure that all out of date policies are reviewed, updated, approved and made available on the Trust's intranet site as soon as possible.	Low	1.1 Accepted - Due to Covid and capacity issues within the finance team the policy/ procedures were not reviewed last financial year, however the policies and procedures are still relevant so per the recommendation is low priority but recognise that they need to go throughtheformalprocess for re-approval.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Jul 2022 November 2022 out of Commiteee Extension agreed: 31 December 2022 (For one of the three Policies). (Two of the three polices have beenapproved). Extension RequestedtoMarch in December update Further extenstion requested in February updatedtoallow CEO to review scheme of delegation beforesubmissiontotheCFC. Ageed Extension Date in April 2023 Audit Committee: 30 June 2023 (For one of the three Policies). (Two of the three polices have beenapproved).	Overdue	Per previous update therevised scheme of delegation will be submitted to the next CFC in September with formal sign of the policy still expectedto take place in December.	Per previous update therevised scheme of delegation will be submitted to the next CFC in September with formal sign of the policy still expectedto take place in December.	The updated scheme of delegation paper was approved by the CFC on the 7th September. The Policy will now be updated to reflect the agreed changes to the Scheme of Delegation for approval by the CFCinDecember.	30th September 2023 Further extension requested tothe 30th December.	18	3	

Managing Attendance at Work - Divisional Deep Dive					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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
	3.2 Pursue the rollout of centralised personnel folders for VCC, in line with the solution implemented within WBS.	Medium	Finalise the business requirement case for centralised workforce folders at VCC (in line with WBS) and implement the system.	Cath O'Brien, Chief Operating Officer	Rachel Hennessy/Paul Wilkins, Director of VCC and Alan Prosser Director of WBS	31st July 2023	Overdue	Prep work completed and dates set up for Medical Records, but manager advised unable to find capacity currently. Awaiting confirmation of dates for roll out from Pharmacy SACT, Nuclear Med, Clinical Audit and Radiology - should be completed in next few weeks	Completed roll out to Nursing Admin, Clinical Audit, Nuclear Medicine, Palliative Care, Radiology. Dates are now set up for Pharmacy and SACT however a lot of prep work has had to be completed prior to rolling out as hierarchies and service are very interrtwined and needed clarity for permissions to be set up with IT accesses. RH has requested pausing Operational Services and CSMO due to restructures.	Dates have been rearranged with Pharnacy/Sact due to sickness absence but will be completed in next couple of weeks. Some departments are advising that due to capacity thay cannotparticpate currently so project has moved to the next section. Dates are now being agreed and in the calendar to roll out to TCS, Finance - Corporate management accounts and fincancial accounts, Divisional Finance, Fundraising, People and OD, and Corporate Governance.	Extension request to 31 December 2023, Due to OCPs and managers lack of capacity	5	1	

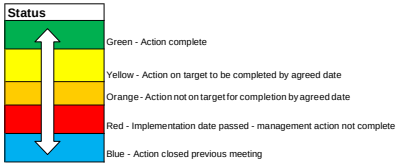
Patient and Donor Experience					Assurance Rating: Reasonable			Date Received at Audit Committee: 12 January 2023						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
	2.1a	Medium	All BI dashboards to include CIVICA patient / donor experience outcomes from service level to Board	~~Nicola Williams, Director of Nursing, AHPs & 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.	Overdue	There are still outstanding issues with the Civica Feed to VCC. Civica are currently working to resolve the issues. This has caused delayed in being able to undertake the work required to build the ETL and requested an extension until the end of October 23 subject to the data being available from CIVICA		Currently still waiting and chasing Civica. No further update.	31-Oct-23	6	2	

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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 2	**Matter Arising 2: Clinical Audit Best Practice** 2.1 The Trust should consider the above points and the wider HQIP 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	Overdue	The Quality Improvement (QI)Hub will focus on overseeing, mentoring and implementing sustained change. Audit outcomes will be actioned and disseminated to clinical groups. The QI Hub will feed into the Trust Quality Hub			Extension Requested 31 December 2023	5	1	
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	Jul-23	Overdue	Discussions have taken place with the Medical director and divisional leads for WBS and VCC to determine the best approach to clinical audit wihin the Trust. Currently scoping the benefits of the current structure and how the two divisions can work together to support clinical audit. function			Extension Requested 31 December 2023	5	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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 1	- 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 andcommunications plan has beendeveloped to the support the launch ofthe 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 Digita	Carl James - Executive Director of Strategic Transformation, Planning and Digita	31st May, 2023	Overdue	Final revisions made to Trust Strategy and pblication and launch will be undertakend as guided by EMB, i.e August 2023.		Final documents received and are undergoing Welsh translation - launch planned for October 2023	~~31 August 2023~~ 31 October 2023	5	1	
Recommendation 5	**Improving reporting on the benefits arising from digital investments** Whilst thare 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 recourced, 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	Business intelligence review undertaken to identify current baseline position of BI requirements, capacity and capability. The next steps will prioritise the development of measures / scorecards (with the digital measures part of this exercise)		BI prioritisation plan agreed at EMB in July 2023. Initial measures for digitall 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 Audt 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



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter arising 1	**Matter arising 1: Late payment of invoices (Operation)** 1.1 The Trust should: a. investigate why these BT invoices are being paid late, liaising with NWSSP Accounts Payable where necessary;	Medium	1.1 a. The recommendation is accepted. Investigation confirmed as part of the audit that the NWSSP Accounts Payable team held and delayed processing	Matthew Bunce, Executive Director of Finance	N/A	Complete	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 1	1.1 The Trust should: b. liaise with NWSSP Procurement Services and Accounts Payable to understand: i. why such late fees are being charged by BT; and why they have signed agreements that they cannot deliver on; ii. how late fees are accounted for (i.e., are they coded to an appropriate loss account in Oracle); and iii. what the wider performance monitoring and accountability mechanisms are to ensure invoices are paid by their due dates (when this is less than 30 days) and to monitor the level of late payment fees incurred.	Medium	b. The recommendation is accepted. Will liaise with NWSSP Accounts Payable to review and understand as per the recommendations and implement as necessary. 31/07/2022	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/07/2022 November 2022 out of Commitee Extension agreed: 31 December 2022. Extension Agreed January 2023 Audit Committee: August 2023.	Complete	**Action Closed** following engagement with BT, the Trust has consolidated the BT invocies to one per division. This will reduce the number of invocies in the system largely mitigating the risk to late payment and incurring late charges.	n/a	n/a	n/a	12	2	Jul-23
Matter arising 2	Matter arising 2: Exception reporting (Operation) 2.1 The Finance team should: a. undertake a formal, documented monthly review of the exception reports, even if no specific matters are identified through the informal weekly reviews;	Medium	2.1 a. The recommendation is accepted. The Divisions will undertake a more formal review which will be signed off by a senior finance business partner. The review will be put in place by the target date.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 2	2.1 The Finance team should: b. take action to address the aged items on the exception reports; and	Medium	2.1 b. The recommendation is accepted. Discussion will take place amongst the Senior Finance Team to agree action to be taken on aged invoices to address the immediate issue and long-term approach which will form part of the review process under item 2.1.a	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 2	2.1 The Finance team should: c. formally monitor progress in clearing aged items at an appropriate forum to ensure action is effectively implemented	Medium	c. The recommendation is accepted. This will be added to the standard agenda of the Financial management meeting under PSPP.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 3	Matter arising 3: Authorisation of proforma invoices (Operation) 3.1 The Trust should: a. remind its authorised signatories only to approve proforma invoices for payment under appropriate circumstances; and	Low	3.1 a. The recommendation is accepted. A reminder will be issued to all staff.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	28/02/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 3	3.1 b. consider producing documented guidance on authorisation of proforma invoices.	Low	b. The recommendation is accepted. Consideration will be given to producing documented guidance on authorisation of proforma invoices.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22

Audit Action Plan

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

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter arising 3	3.2 The Finance team should investigate the specific circumstances of the exception noted in our testing (details have Low been provided) to understand: a. whether a duplicate payment has been made;	Low	3.2 a. The recommendation is accepted. The item has been investigated and no duplicate payment made.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 3	3.2 b. whether the goods were received; and	Low	b. The recommendation is accepted. The item has been investigated and goods received.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 3	3.2 c. why the proforma was authorised for payment, liaising with NWSSP Accounts Payable if necessary.	Low	c. The recommendation is accepted. NWSSP has advised that this specific supplier operates a cash account requiring payment against estimate before items are released. Practice is not local to the Trust and NWSSP would be required to undertake any further actions in particular ensuring the process for this supplier (and any other suppliers operating cash accounts requiring payment against estimate) is incorporated into any existing documented guidance in place or developed for proformainvoices.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 4	Matter arising 4: Compliance with Fixed Assets FCP (Operating effectiveness) 4.1 The Finance team should remind the divisions of the requirement to complete, approve and submit asset disposal forms prior to asset disposal, not least to ensure value for money is obtained from assets' residual values.	Medium	4.1 The recommendation is accepted. Reminders will be provided at the Capital Planning Group and Divisional Business Planning Group meetings.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 4	4.2 a. The Trust should update its Fixed Assets FCP to: − reflect actual practice regarding maintenance of the FAR, capital ledgers and AUC and the related reconciliations to the general ledger; and − incorporate the asset verification coverage target of 80%.	Medium	4.2 a. The recommendation is accepted and the FCP will be updated.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	28/02/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Matter arising 4	4.2 b. The Audit Committee should approve the updated FCP.	Medium	4.2 b. The recommendation is accepted. The updated FCP will be endorsed at the Capital Planning Group for approval by the Audit Committee. .	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & reporting Manager	31/05/2022 November 2022 out of Commiteee Extension agreed: 26 January 2023. Extension Request agreed in April 2023 Audit Committee: 31 July 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 has been scheduled for the beginning of Sep to review the procedure following significant changes following the Establishment of SCB. **Request for further extension to end of December**	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 updated implementation date. A meeting of key personnel met at the Start of Sep with a further meeting scheduled for wc18th September to udpate and review the procedure following significant changes following the Establishment of SCB.	31 December 2023	19 months	3	
Previous Matter arising 1	Previous Matter arising 1: Pursuance of Private Patient (PP) debts (Operating effectiveness) 1.1 a. We concur with the actions taken by the Trust to address the aged Private Patient debt balance. The Trust should maintain its focus on this area through formal continuous monitoring, including reporting to Audit Committee until an acceptable position is reached.	Medium	1.1 a. The recommendation is accepted. A detailed aged debt position has been documented, with monitoring arrangements in place including the status of each debt line and the outcome of actions taken to-date. A standard report will be developed for continuous monitoring by the VCC SMT and EMB and reported to the Audit Committee detailing the position and progress made until the Audit Committee agree they have assurance that private patient debt management is acceptable.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	31/05/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Sep-22

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Previous Matter arising 1	1.1 b. To support reporting on Private Patient aged debt, the Trust should consider identifying formal key performance indicators with clear targets, for example: • split of debt between self-payers and insured; • percentage of aged amounts vs total debt; • percentage of debt recovered vs total debt (with a similar sub-metric for aged debts); • maximum accepted level for Private Patient aged debts (by percentage and / or value) and monitoring performance against this at an appropriate forum to ensure accountability.	Medium	b. The recommendation is accepted. Key performance indicators are being collated from a patient and financial perspective and the measures identified within this recommendation will be considered and presented to VCC SMT and then EMB for formal approval / sign off.	Matthew Bunce, Executive Director of Finance & Cath O'Brien, Chief Operating Officer	Head of Outpatient, Medical Records and Private Patient Services	30/04/2022	Action Closed		n/a	n/a	n/a	n/a		Aug-22
Previous Matter arising 2	Previous matter arising 2: Unallocated and Unidentified Receipts (Operating effectiveness) 2.1 a. The Trust should: i. discuss the aged unallocated/unidentified receipts position with Counter Fraud, Audit Wales and Welsh Government to understand their view on how this balance should be addressed; and ii. based on the above discussions, take appropriate action to address the aged unallocated/unidentified receipts balance.	Medium	2.1 a. The recommendation is accepted. Discussions will take place with relevant parties and appropriate action taken. Due to the upcoming year end, it is likely that Audit Wales and Welsh Government will wish to prioritise discussions on that, and the target date is therefore reflective of that.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	30/06/2022 **Extension requested to 30/09/2022** **Extension requested to 30/11/2022.** November 2022 out of Commiteee Extension agreed: 30 November 2022.	Action Closed		n/a	n/a	n/a	n/a		Dec-22
Previous Matter arising 2	2.1 b. We concur with the Finance team's intention to increase the frequency of its Long Term Agreement reconciliation. We recommend that the Finance team should undertake this review at monthly to support and ensure aged unallocated and unidentified receipts balances are reduced to a minimum level, ensuring the review is documented, and evidenced.	Medium	b. The recommendation is accepted. Monthly reconciliations of LTA money due and received are now standard practice.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	Completed	Action Closed		n/a	n/a	n/a	n/a		Jul-22
Previous Matter arising 2	c. The Trust should ensure the SOP for Private Patients unallocated and unidentified receipts is approved at an appropriate forum (e.g., by the Audit Committee).	Medium	c. The recommendation is accepted. A Departmental SOP has been drafted for the management of unallocated and unidentified receipts, with significant work undertaken to date resulting in a reduction in the reported aged debt position. The SOP will be submitted for approval to the Audit Committee.	Cath O'Brien, Chief Operating Officer	Ann-Marie Stockdale, Head of Outpatients, Medical Records and Private Patient Service	30/04/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Aug-22
Previous Matter arising 3	Previous matter arising 3: Management of Aged Debts (Operating effectiveness) 3.1 We concur with the Trust's continued focus on general and charity aged debts. We further recommend: a. Charity debts: the Trust should formally review its processes for charity invoicing and debt collection, both internally between finance and the divisions and through discussions with relevant charities (particularly Macmillan and Marie Curie) to identify inefficiencies within the process;	Low	3.1 a. The recommendation is accepted. Increased frequency of liaison and enhanced formal processes will be put in place both internally and with partners	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	31/03/2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Jul-22
Previous Matter arising 3	3.1. b. General debts: the Trust should consider identifying and monitoring formal key performance indicators with clear targets for general debts, similar to those set out in recommendation 1.1(b) of prior year recommendation 1.	Low	b. The recommendation is accepted. Consideration will be given to identifying and monitoring formal key performance indicators with clear targets for general debts.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022 Complete but request to keep action open until **October 2022 meeting** to allow review	Action Close	n/a	n/a	n/a	Update October 2022: Complete. Action should have been marked as complete for October 2022 Audit Committee.	n/a	n/a	Sep-22

Audit Action Plan

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

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Charitable Funds 2021/22					Assurance Rating: Reasonable		Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matther arising 1	Matter arising 1: Charitable Funds Policies (Design) 1.1 Management should ensure that all out of date policies are reviewed, updated, approved and made available on the Trust's intranet site as soon as possible.	Low	1.1 Accepted - Due to Covid and capacity issues within the finance team the policy/ procedures were not reviewed last financial year, however the policies and procedures are still relevant so per the recommendation is low priority but recognise that they need to go through the formal process for re-approval.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Jul 2022 November 2022 out of Commiteee Extension agreed: 31 December 2022 (For one of the three Policies). (Two of the three polices have been approved). Extension Requested to March in December update Further extenstion requested in February updated to allow CEO to review scheme of delegation before submission to the CFC. Ageed Extension Date in April 2023 Audit Committee: 30 June 2023 (For one of the three Policies). (Two of the three polices have been approved).	Overdue	Per previous update the revised scheme of delegation will be submitted to the next CFC in September with formal sign of the policy still expected to take place in December.	Per previous update the revised scheme of delegation will be submitted to the next CFC in September with formal sign of the policy still expected to take place in December.	The updated scheme of delegation paper was approved by the CFC on the 7th September. The Policy will now be updated to reflect the agreed changes to the Scheme of Delegation for approval by the CFC in December.	30th September 2023 Further extension requested to the 30th December.	18	3	
Matther arising 2	Matter arising 2: Retrospective Purchase Orders (Operation) 2.1 Management should remind requisitioners and approvers that purchase orders should be placed on the Oracle system prior to the goods and services being ordered and received.	Medium	2.1 Accepted – This is policy and should be followed. The Charitable funds finance manager will review monthly reports shared by NWSSP Accounts Payable team and specifically target repeat offenders. A reminder will be sent to all Fund holders and requisitioners.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	May-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 3	Matter arising 3: Appropriate evidence for, and timely claiming of, expenses (Operation) 3.1 Management should: a. communicate to relevant individuals and authorisers the requirement for timely submission of expense claims supported by appropriate evidence; and	Low	3.1 a. Accepted. Whilst we do request a timely submission of claims, the reason this was held up was due to Covid, and this has been confirmed by the consultant in question when asked for the reason in the delay. We do however recognise that this delay is excessive and the employee has been reminded of the importance in submitting claims in a timely manner.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Apr-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 3	3.1 b. ensure that expenses submitted late or without appropriate evidence are appropriately challenged before payment and the challenge and justification for payment are clearly documented.	Low	3.1 b. Accepted. This is linked to the above and it is not uncommon for receipts to go missing, however we were aware that the named individual went by flight to Sierra Leone and the cost of the ticket / reclaim was in line with what you would expect to pay. We do however recognise that this needs to be clearly documented, such as printing off an illustration of the cost of a flight to Sierra Leone in order to accompany and support the claim, and articulating this with the employee at the time.	Matthew Bunce, Executive Director of Finance	Charitable Funds Finance Manager / Steve Coliandris	Apr-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 4	Matter arising 4: Acknowledgement letters (Operation) 4.1 Management should update the 'Database Donation Entry instructions' document to detail when acknowledgment letters are not issued.	Low	4.1 Accepted – the manual will be updated	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22

Audit Action Plan

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

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Charitable Funds 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022						
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matther arising 4	4.2 Management should review the 13 receipts identified above to satisfy itself that it was appropriate that an acknowledgement letter was not issued.	Low	4.2 Accepted – review is being undertaken	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 5	Matter arising 5: Allocation of funds (Operation) 5.1 Management should: a. develop guidance on when funds should be allocated to funds other than the general-purpose fund and what supporting evidence should be retained in such circumstances;	Low	5.1 a. Accepted – All funds are donated into the General funds unless specifically requested from a Donor or a fundraising event / activity is raising money for that particular fund. We can develop a quick guide to demonstrate this. It will be in the guidance that we expect written confirmation when donations are requested to be received into another fund, and we will make every effort to ensure that the guidance is followed.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 5	5.1 b. confirm that the four above receipts have been posted to the correct fund number code and update the donation database as necessary; and	Low	5.1 b. Accepted – All donations have been reviewed and confirmed that they are in the correct place.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 5	5.1 c. consider whether a review of the accuracy of the information in the database is required.	Low	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 6	Matter arising 6: Incorrect fundraising event noted (Operation) 7.1 Management should: a. remind staff of the need for accurate recording of fundraising events in the donation database;	Low	7.1 a. Accepted - the Fundraising team are aware and have been reminded that it is important that information is recorded accurately in the database.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Apr-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 6	7.1 b. confirm that the four above receipts have been allocated to the correct fundraiser and update the donation database as necessary; and	Low	7.1 b. Accepted - A review will be undertaken to ensure that the receipts have been allocated to the correct fundraiser, however we are confident that they are in the correct fund for accounting purposes.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	May-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 6	7.1 c. consider whether a review of the accuracy of the information in the database is required (see also MA5).	Low	c. Accepted – An appropriate level of review of accuracy of the information in the database will be undertaken.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Matther arising 7	Matter arising 7: Advancing Radiotherapy Fund Board Terms of Reference (Operation) 8.1 Management should ensure the ARF Board ToR is formally approved and kept under review.	Low	8.1 Accepted – The ToR has been reviewed and regularly updated, however due to the lack of meetings which were stood down for a period during Covid it has delayed formal approval for the latest version. The latest version of the ToR is going to ARF Board on 27th April for approval.	Matthew Bunce, Executive Director of Finance	Moondance Programme Manager / ARF Programme Manager (Elizabeth Crompton) / ARF Admin Support (Hannah Fox)	Apr-22		n/a	n/a		n/a	n/a	n/a	Jul-22
Previous matter arising 3	Previous matter arising 3: Desktop Procedure - Monies Received (Control design) 3.1 Management should draw up a desktop procedure that details the processes to be followed by the fundraising staff and finance staff for recording, safeguarding and banking of Charitable Funds income.	Medium	3.1 Accepted – a new procedure will be developed.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22
Previous matter arising 3	3.2 Management should ensure that the original recommendation is reinstated on the Trust's audit tracker.	Medium	3.2 Accepted – original recommendation will be reinstated.	Matthew Bunce, Executive Director of Finance	Alaric Churchill, Charity Director	Jun-22	Action Closed	n/a	n/a		n/a	n/a	n/a	Jul-22

Audit Action Plan

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

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Finance & Service Sustainability: Budgetary Control & Savings Plans | **Assurance Rating: Reasonable** | **Date Received at Audit Committee: 04 October 2022**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update June 2023	Update July 2023	Update August 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matter Arising 1	**Availability of the BC FCP (Operation)** 1.1 The BC FCP should be made available to all BHs. BHs should be made aware of its location.	Low	Recommendation accepted with the FCP already been made available on the Trust Intranet site. BHs will be informed of its location.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting /David Osborne, Head of Business Partnering	31.10.2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Nov-23
Matter Arising 2	**Budget Approval (Operation)** 2.1 The Trust Board should formally consider if it receives sufficient information to approve the annual budget and meet the requirement of the SO/SFIs.	Low	Prior to the development of the 2022-23 budget submission to Trust Board Management will review the SO/SFI requirements with regards to Budget Setting (Section 5.1), taking into account the Responsibilities and Delegation outlined in Section 2.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	30.04.2023	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	May-23
Matter Arising 3	**Distribution / Acknowledgement of Budget Sub-Delegation Letters (Operation)** 3.1 Budget sub-delegation letters should be formally issued and acknowledged by all BHs, in line with the sub- delegation requirements of the budget delegation letters.	Medium	The BC FCP requires both Directors via chief Executive and Divisional Directors via the Chief Operating Officer to formally acknowledge the delegation with letters issued. There is flexibility for further sub-delegation with budget packs issued to BHs. Formal acknowledgement of sub-delegation to all BH's however will be incorporated as a requirement from next year.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering / Steve Coliandris, Head of Financial Planning & Reporting	30.04.2023 Extension Date Agreed July 2023 Audit Committee 30th June 2023.	Complete	Remaining DECL letters on course to be issued by requested extension date.	**Complete** This action can be closed. All DECL letters have now been issued.	n/a		2	1	Jul-23
Matter Arising 3	3.2 The Trust should consider including timeframes for the issue and acknowledgement of delegation letters within the BC FCP.	Low	Management will review and update the FCP to include timescales for DECL letters being sent and expected acknowledgement of receipt and acceptance in line with Budgetary Delegation expectations set in Section 5.2 of the SO/SFIs.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting	30.04.2023 To Note: Date amended from 30.01.2022 as error on Audit Report. Extension Date Agreed July 2023 Audit Committee 31st July 2023.	Complete	FCP to be summited to EMB in June for endorsement and formal approval of audit committee in July.	FCP is on the Audit committee agenda for approval.	**Complete** FCP was approved by Audit committee on the 26th July		3	1	Aug-23
Matter Arising 4	Timelines of Budget Holder Reporting (Operation) 4.1 The Trust should ensure BH information is issued in a timely manner. Inclusion of reporting and BH meeting timeframes in the month-end financial timetable may support this.	Medium	Management acknowledges some occurrences of delayed reporting due to temporary resource issues, however regular reports and meetings do take place. Timeframes to be included and adhered to within monthly timetable, with formal confirmation and records of completion.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering	31.10.2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Nov-22
Matter Arising 4	4.2 The Finance Team should liaise with the divisions to ensure the divisional management team meetings receive and consider written finance reports.	Low	Verbal updates have been provided on occasion due to timing issues. Management will ensure that written reports are available to Divisional Teams and will be retained in the records of SMT meetings.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering	31.10.2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Nov-22
Matter Arising 5	**Plans to Support Realisation of Savings (Operation)** 5.1 The Trust should develop clear implementation plans (or an appropriate alternative dependent upon the savings plan) for its savings plans. The implementation plans should: • cover financial and non-financial actions, including timescales and responsible individuals; and • be monitored at an appropriate forum (plan dependent) within the Trust. Significant changes to savings plans should be formally approved at an appropriate level within the Trust, and the related implementation plan updated accordingly.	Medium	Accountable leads and associated actions plans to be reported at mothly Divisional SMT's and /or Executives with a review of actions required to deliver the plans on time. Assurance to the Trust Board will continue to be provided via established financial reporting mechanisms whereby the Finance Report includes details of any corrective actions required as a result of saving plans reviews at Divisional or Corporate level.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering /Steve Coliandris, Head of Financial Planning &Reporting	31.10.2022	Action Closed	n/a	n/a	n/a	n/a	n/a	n/a	Nov-22
Matter Arising 6	**Evidencing Budget Monitoring / Actions to Address Variances (Operation)** 6.1 The Finance team should: • ensure BH meetings are evidenced with notes/action logs; • track whether BHs and FBPs are meeting in a timely manner (see also recommendation 4.1); and • ensure actions to address adverse variances are clearly identified and trackable, including responsible individuals and timescales. We can provide the Finance team with example templates used elsewhere for BH meeting notes / actions if required.	Medium	Management accepts that Budget Holder and FBP capacity has occasionally been limited during the COVID recovery period due to operational pressures on the service. Management will schedule and formally record meeting attendance and note reasons for non-compliance. Notes and actions are taken with examples provided during the audit. Actions and escalations will be formally logged in a consistent manner across all Divisions. Enhancement and consistency of budget reporting to be picked up as part of Divisional team review/ PADR.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering / Steve Coliandris, Head of Financial Planning & Reporting	31.10.2022 Extension agreed for another 6 months at January 2023 Audit Committee - July 2023.	Complete	Capacity issues in the finance team have delayed implementation, however this remains on target to be completed In line with the agreed revised implementation date.	**Complete** This action can be closed, FBP are evidencing BH meetings via a schedule and are recording actions. actions to addresses issues are being recorded.	n/a	31st July 2023	9	1	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

Managing Attendance at Work - Divisional Deep Dive					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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Strengthening attendance at MAAW training (Operation)** 1.1 Share MAAW training attendance and feedback data with divisional and directorate/OSG management to enable local action to address identified low training attendance.	Medium	Workforce Education Development Manager to ensure this is available/sent to Managers/SLT/SMT as part of their monthly performance feedback.	Cath O'Brien, Chief Operating Officer	~~Angela Voyle Smith, Workforce Education Development Manager~~ Claire Budgen, Head of Organisational Development	31 December 2022	Action Closed	n/a	n/a		Extension requested in February Update: 31 March 2023 - to enable discussions which will confirm all actions have been completed. This has been delayed due the post of Workforce Development Manager being vacant.	n/a	n/a	March/April 2023
	1.2 Consider reviewing the MAAW training feedback mechanisms in place and whether they adequately capture the required feedback to assess and respond to current training attendance levels.	Low	Review current mechanism for obtaining course feedback.	Cath O'Brien, Chief Operating Officer	~~Angela Voyle Smith, Workforce Education Development Manager~~ Claire Budgen, Head of Organisational Development	31 December 2022 Extension request agreed April 2023 Audit Committee: 30 April 2023. The Workforce Development Manager post is vacant and this review will take time out of another team member's work therefore an extension to 30 April 2023 wil allow the work to be completed as required.	Action Closed	n/a	n/a		30 April 2023. The Workforce Development Manager post is vacant and this review will take time out of another team member's work therefore an extension to 30 April 2023 wil allow the work to be completed as required.	4	1	May-23
	1.3Consider mechanisms to further support line managers in the application of discretion or use of innovative solutions to support sustained attendance or RTW	Low	Case studies on managing absence are already included in the Fundamentals of Management Training Package, these will also be added to the MAAW Training package to further support learning, on managing absence. People and OD team will continue to consider other mechanisms that may be useful.	Cath O'Brien, Chief Operating Officer	Judy Stafford, People and Relationships Manager	31 January 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	March/April 2023
Matters Arising 2	**Accuracy of absence recording (Operation)** 2.1 Remind managers of the importance of accurate absence recording and reiterate the process for recording Covid absences.	Low	Managers are regularly reminded of requirement and importance of accurate reporting. Specific feedback will be given to all managers and raised at SLT/SMT meetings.	Cath O'Brien, Chief Operating Officer	Senior People and OD Business Partners. Sue Price (for WBS and Corporate), Donna Dibble (for VCC).	31st October 2022	Action Closed	n/a	n/a		n/a	n/a	n/a	Jan-23

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

Managing Attendance at Work - Divisional Deep Dive					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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
	2.2 Consider requesting that line managers review absences recorded as non-Covid on ESR during the pandemic to ensure they have been recorded accurately.	Low	Managers will be asked to sample their ESR information to assess accuracy but there will not be a formal review due to current service demands and benefits gained.	Cath O'Brien, Chief Operating Officer	Rachel Hennessy/Paul Wilkins, Director of VCC and Alan Prosser Director of WBS	30th November 2022	Action Closed	n/a	n/a		n/a	n/a	n/a	March/April 2023
Matters Arising 3	**Demonstrating compliance with the MAAW Policy (Operation)** 3.1 Remind line managers of the importance of: • timely storage of absence records in the appropriate location, which is accessible in their absence, including the information noted as outstanding in this audit (a detailed list has been provided to management); and • ensuring absence records contain sufficient information to justify decisions made and actions taken, including for short-term absences, delays in LTS meetings, application of discretion, and discussions around sustained attendance / returning to work.	High	Develop key messages for SLT/SMT members, for cascade to their managers, which defines the process for storage of such information i.e, shared files, use of personal 'P' drives, password protected, accessibility etc. Develop examples of good practice and checklist examples for cascade through Divisions and use in training events.	Cath O'Brien, Chief Operating Officer	Judy Stafford, People and Relationships Manager Judy Stafford, People and Relationships Manager	30th November 2022 Extension Agreed April 2023 Audit Committee: 31 August 2023 31st December 2022 Extension Agreed April 2023 Audit Committee: 31 August 2023	Action Closed	n/a	n/a		n/a	9 Months 8 Months	n/a	May-23
	3.2 Pursue the rollout of centralised personnel folders for VCC, in line with the solution implemented within WBS.	Medium	Finalise the business requirement case for centralised workforce folders at VCC (in line with WBS) and implement the system.	Cath O'Brien, Chief Operating Officer	Rachel Hennessy/Paul Wilkins, Director of VCC and Alan Prosser Director of WBS	31st July 2023	Overdue	Prep work completed and dates set up for Medical Records, but manager advised unable to find capacity currently. Awaiting confirmation of dates for roll out from Pharmacy SACT, Nuclear Med, Clinical Audit and Radiology - should be completed in next few weeks	Completed roll out to Nursing Admin, Clinical Audit, Nuclear Medicine, Palliative Care, Radiology. Dates are now set up for Pharmacy and SACT however a lot of prep work has had to be completed prior to rolling out as hierarchies and service are very interrtwined and needed clarity for permissions to be set up with IT accesses. RH has requested pausing Operational Services and CSMO due to restructures.	Dates have been rearranged with Pharnacy/Sact due to sickness absence but will be completed in next couple of weeks. Some departments are advising that due to capacity thay cannot particpate currently so project has moved to the next section. Dates are now being agreed and in the calendar to roll out to TCS, Finance - Corporate management accounts and fincancial accounts, Divisional Finance, Fundraising, People and OD, and Corporate Governance.	Extension request to 31 December 2023, Due to OCPs and managers lack of capacity	5	1	
	3.3 Implement the planned programme of audits to ensure continued adherence to the MAAW Policy and update EMB on the status of this programme.	Medium	A rolling programme of audits was agreed in September 2021 by EMB; this was impacted by COVID and replaced by spot audits in hotspot areas due to service pressures. The rolling programme agreed is now back on track and is ongoing with targeted dates on updates to EMB in December 2022 and March 2023.	Cath O'Brien, Chief Operating Officer	n/a	n/a	Action Closed	n/a	n/a		n/a	n/a	n/a	Jan-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 *

*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 July 2023	Update August 2023	Update September 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 of 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 levels 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	Complete	Tina Jenkins to link with Emma Powell to establish how this links with 2.1a	**Complete.** Procedure developed & published on intranet site.			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	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 the intranet.	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	Complete	See update relating to 1.1a above.	**Complete.** in place aligned with directorate leads.			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	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.	Overdue	There are still outstanding issues with the Civica Feed to VCC. Civica are currently working to resolve the issues. This has caused delayed in being able to undertake the work required to build the ETL and requested an extension until the end of October 23 subject to the data being available from CIVICA.		Currently still waiting and chasing Civica. No further update.	31-Oct-23	6	2	
	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		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 reporting mechanisms.	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	Complete	See update relating to 1.1a above.	**Complete.** Included in procedure.			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 UNHS Trust

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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)
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	Complete	New year PMF reports rolled forward to 2023/24 April /May PMF to EMB Run 29/06/23 followed by QSP Cttee 13/07/23 and Trust Board 27/07/23. Benefits of the initial PMF project initiative are significant and are being delivered. Contingency plans are also now in place within the Planning Team to increase resilence including ongoing training and support (see below)	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	Complete	PMF training and support ongoing to all staff inputing to PMF Teams channel. Greater delegation of responsibility to VCS and WBS leads for PMF report production with central co-ordination of final product. This ongoing support from Planning Team is now business as usual.	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 Henessy, Interim Director of VCC / Paul Wilkins, Director of VCC	Q2 2023/24	Complete	Regular PMF reporting routine established across VCS, WBS and Trust-wide services with an enhanced range of KPIs and supporting analysis including SPC charting data and analysis of performance. WBS and VCS Senior Leadership Teams meet monthly to review PMF reports followed by Monthly Performance Review meetings carried out by the Chief Operating Officer prior to full EMB, QSP and Trust Board review.	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	Complete	New year 2023/24 PMF reports now incorporate March 2023 as baseline which is considered appropriate, as it gives the current context, in addition to monitoring against statutory and local stretch targets. Predictive analytics will be considered for future development.	n/a	n/a	n/a	Jul-23

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)
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	Complete	KPI Glossary of Terms and Calculation Definitions now consolidated into a single document. This document not only records in detail the measurement basis for all KPIs (both statutory and Local stretch targets) but is also usedas an 'audit trail' to record the rationale for aall additions and removals (see also below)	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	Complete	KPI Glossary of Terms and Calculation Definitions now consolidated into a single document. This document not only records in detail the measurement basis for all KPIs (both statutory and Local stretch targets) but is also usedas an 'audit trail' to record the rationale for aall additions and removals (see also below)	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 Henessy, Interim Director of VCC / Paul Wilkins, Director of VCC and Peter Gorin, Head of Corporate Strategic Planning & Performance	Q2 2023/24	On Target	PAF Subgroup 27/7/23 progressing a VUNHST PAF and Accountability Scheme of Delegation and will include responsibilities around evidence retention	PAF Subgroup 10/8/23 to review progress on VUNHST PAF and Accountability Scheme of Delegation	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		
Matter Arising 5	5.2 Develop and document processes for assurance 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	On Target	PAF Subgroup 27/7/23 progressing a VUNHST PAF and Accountability Scheme of Delegation and will include responsibilities around evidence retention	PAF Subgroup 10/8/23 to review progress on VUNHST PAF and Accountability Scheme of Delegation	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		
Matter Arising 5	Ensure the detailed guidance for each metric within the KPI glossary robustly details assurance mechanisms over the quality of source data in the data confidence section, including considering and relying on any existing assurance mechanisms.	Low	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	Complete	KPI Glossary of Terms and Calculation Definitions now consolidated into a single document. This document is not only recors also used as an 'audit trail' to record the rationale for aall additions and removals but also includes an assessment of the data source quality i.e. does the data come from an automated system or from manual survey data and input?	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 - Review of Quality Governance Arrangements - VUNHST | **Assurance Rating: N/A** | **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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
R1	At the time of writing, the Trust had recently developed 10 new Quality Improvement Goals; however, they are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved on time. Going forward, the Trust should ensure that Quality Improvement Goals are underpinned with specific, time-bound actions	N/A	Trust will ensure 2023-24 and future years quality Goals are specific (SMART) and timebound	Nicola Williams, Executive Director Nursing, AHP and Health Science	Nicola Williams, Executive Director Nursing, AHP and Health Science	March 2023 Extension Request Agreed April 2023 Audit Committee: 30 April 2023	Complete	Achieved for four goals - the leadership improvement goal identified linked to psychological safety. The measureable outcome is being determined. - revised date end August.	On track to achieve the 31/08/2023 revised date.	**Complete**. SMART aims developed through Trust Safe Care Collaborative Implementation Group with review on monthly basis as projects develop.	31-Aug-23	5	2	Sep-23
R2	To date, Board committees' scrutiny of the Board Assurance Framework has focused on its development and format. As soon as possible, the Trust should ensure that each committee incorporates a review of the strategic risks assigned to them within their cycles of business and: a) Provide appropriate consideration of each of the controls and sources of assurance, and	N/A	a. Agreement of Committee mapping to Trust Assurance Framework risks complete and endorsed by Strategic Development Committee in October 2022 for implementation through next governance cycles, starting from November 2022. (Cross-reference to the Governance, Assurance and Risk work under the Building Our Future Together Programme (BOFT) - Project Trust Assurance Framework 4.0).	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	January 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	March/ April 2023
R2	b) Scrutinise progress to address gaps in controls and assurances.	N/A	b. Further scrutiny and evidence of this, in line with the comments made in the report, will be actioned as part of the next governance cycle review of the Trust Assurance Framework	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	January 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	March/ April 2023
R3	Risk registers presented to meetings do not always include enough information to allow good scrutiny. The Trust should: a) Determine what information is needed in risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (such as including opening, current and target risk scores, and sufficient clarity on existing controls and mitigating action).	N/A	a) Quality of data and consistency of reporting is a focus of the current risk work. (Cross-reference to Governance, Assurance and Risk work under BOFT - Project Risk 4.0 & Risk 5.0)	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	March 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	March/ April 2023
R3	b) If risks appearing in the Trust Risk Register have been discussed in other agenda items, provide suitable cross references in the cover report.	N/A	b) To be included in new Cover Paper Template and Risk Register report (Cross-reference to Governance, Assurance and Risk work under BOFT - Project GOV 2.0).	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	January 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	March/ April 2023
R3	c) Executive risk owners should lead discussions on risks within their areas of responsibility.	N/A	c) Implement from next governance cycle.	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	January 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	March/ April 2023
R4	a) Progress to develop a Trust-wide action plan to address findings from the NHS Staff Survey slowed due to the impact of the pandemic. The Trust should progress work to develop the action plan as soon as possible and: a) Undertake work to understand why some staff feel that the Trust does not take effective action to deal with bullying, harassment or abuse.	N/A	a) Trust-wide conversations are underway regarding the way staff feel about working in the organisation. The outputs of this work will give a picture of the culture of the organisation and enable the next iteration of the Trust Values. Part of this engagement work will also be extended to address particular feedback on dealing with bullying, harassment or abuse.	Sarah Morley, Executive Director of Organisational Development and Workforce	Sarah Morley, Executive Director of Organisational Development and Workforce	January 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	Jan-23
R4	b) Undertake work to understand why some staff may feel that the Trust does not act adequately to address concerns.	N/A	b) The work described at a) will also address the issue of dealing with concerns raised in the workplace.	Sarah Morley, Executive Director of Organisational Development and Workforce	Sarah Morley, Executive Director of Organisational Development and Workforce	January 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	Jan-23
R5	Some of the attendees of meetings that consider quality and safety matters in VCC felt that there is duplication of coverage, and that not all meetings had appropriate representation. When operationalising the Quality Hubs, the Trust should for VCC and WBS and Trust-wide. a) Ensure that the group structures and meeting remits avoid unnecessary duplication of coverage. b) Ensure that attendees of each meeting are appropriate and provide adequate representation of relevant disciplines. c) Ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines.	N/A	Integrated Quality and Safety Group to be established (19th October 2022). The Group will take responsibility for reviewing Trust-wide quality and safety related meeting structures, including required representation. Output to be approved by Executive Management Board and the Quality, Safety and Performance Committee. It is noted however, that this will require ongoing review as the Trust and Integrated Quality and Safety Group matures.	Lauren Fear, Director Corporate Governance and Chief of Staff and Nicola Williams, Executive Director Nursing, AHP and Health Science.	• Nicola Williams, Executive Director Nursing, AHP and Health Science; • Lauren Fear, Director Corporate Governance & Chief of Staff; • Emma Stephens, Head of Corporate Governance	March 2023	Action Closed	n/a	n/a		n/a	n/a	n/a	March/ April 2023
R6	Information in reports and performance data are sometimes out of date. The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee meeting is as up to date as possible, covering agreed time periods.	N/A	Reporting cover periods to be made explicit as part of Committee agenda setting and work plan.	Lauren Fear, Director Corporate Governance and Chief of Staff and Nicola Williams, Executive Director Nursing, AHP and Health Science.	• Nicola Williams, Executive Director Nursing, AHP and Health Science; • Lauren Fear, Director Corporate Governance & Chief of Staff; • Emma Stephens, Head of Corporate Governance	From January 2023 Quality, Safety and Performance Committee	Action Closed	n/a	n/a		n/a	n/a	n/a	March/ April 2023

Audit Action Plan

Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red- Implementation date passed - Action not complete

Blue - Action closed previous meeting

Priority	
Low	< 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 July 2023	Update August 2023	Update September 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Recommendation 1	**Improving administrateive governance arrangements** We found that opportunities remian 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	n/a	n/a	May-23
Recommendation 1	- 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 andcommunications plan has beendeveloped to the support the launch ofthe Trust 10-year strategy in May 2023. This willinclude publishing the strategy on the Trust website	Carl James - Executive Director of Strategic Transformation, Planning and Digita	Carl James - Executive Director of Strategic Transformation, Planning and Digita	31st May, 2023	Overdue	Final revisions made to Trust Strategy and pblication and launch will be undertakend as guided by EMB, i.e August 2023.		Final documents received and are undergoing Welsh translation - launch planned for October 2023	~~31 August 2023~~ 31 October 2023	5	1	
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 templates. 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	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 2023-2026 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 (phase 2)	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	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	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	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 recourced, 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	Business intelligence review undertaken to identify current baseline position of BI requirements, capacity and capability. The next steps will prioritise the development of measures / scorecards (with the digital measures part of this exercise)		BI prioritisation plan agreed at EMB in July 2023. Initial measures for digitall 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.				
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	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	Business intelligence review undertaken to identify current baseline position of BI requirements, capacity and capability. The next steps will prioritise the development of measures / scorecards (with the digital measures part of this exercise)		BI prioritisation plan agreed at EMB in July 2023. Initial measures for digitall 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	
	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 *

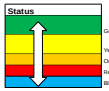
* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Cyber Security Final Internal Audit Report | **Assurance Rating: Substantial** | **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 May 2023	Update June 2023	Update July 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Matter Arising 1: Improvement Plan Progress (Operation)** 1. The defined actions within the improvement plan should be progressed. Given the current resource constraints, a prioritised task list should be produced for agreement, which makes clear what tasks cannot be progressed and the relevant risk impact.	Medium	1.1a Progress against the Cyber Security Strategic Plan will be reviewed as part of its usual review cycle via the Quality, Safety & Performance Committee in May 2023. As part of this review, a further assessment will be made in respect of the timetable for delivery of future planned work, aligned to available Cyber Security resources within the Digital Services team.	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl Taylor – Chief Digital Officer	30th June 2023	Complete	The Cyber Security Strategic plan has been reviewed in light of the audit action and is due to go to the July QSP meeting as part of the new cycle of business.	The Cyber Security Strategic plan has been reviewed in light of the audit action and is due to go to the July QSP meeting as part of the new cycle of business.	**Complete** The Cyber Security Strategic plan has been reviewed in light of the audit action and is on July QSP meeting for the 14th July as part of the new cycle of business. This set out the actions that would be priorised.				Jul-23
Matters Arising 2	**Matter Arising 2: Reporting (Operation)** Training on cyber security / Digital should be provided to the members of the QSP.	low	Board development sessions to be held in 2023/24, to include members of QSP Committee.	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl Taylor – Chief Digital Officer	31st March 2024	Complete	Planning to include as part of the Board Development session in June '23 with Oct '23 as the backup option.	Cyber has been added to the Oct'23 Board Development session. On the 3rd July there is an All Wales Board briefing on Cyber to which the VUNHST Board have been invited. The Oct'23 session will then pick up on the topics identified. Action closed	Action complete June 2023 but didn't get recorded at June EMB /July Audit Committee. Will be now included in July updates.				Jun-23

Audit Action Plan



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - Action not complete

Blue - Action closed previous meeting

Priority	
Low	< 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 July 2023	Update August 2023	Update September 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	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	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	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 recontled. 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	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	Jun-23
Matters Arising 2	**Matter Arising 2: Clinical Audit Best Practice** 2.1 The Trust should consider the above points and the wider HQIP 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	Overdue	The Quality Improvement (QI)Hub will focus on overseeing, mentoring and implementing sustained change. Audit outcomes will be actioned and disseminated to clinical groups. The QI Hub will feed into the Trust Quality Hub			Extension Requested 31 December 2023	5	1	
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	Jul-23	Overdue	Discussions have taken place with the Medical director and divional leads for WBS and VCC to determine the best approach to clinical audit whin the Trust. Currently scoping the benefits of the current structure and how the two divisions can work together to support clinical audit. function			Extension Requested 31 December 2023	5	1	
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	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	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	On Target	VCC quality improvment hub being developed.			n/a	n/a	n/a	
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	Complete	**Complete** Governace and reporting process map has been developed. Once signed off will be added to the intranet	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	May-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

Information Governance 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 May 2023	Update June 2023	Update July 2023	Requested Extension Date	Extension (Months)	Extension Requests Total	Date Completed
Matters Arising 1	**Matter Arising 1: Areas for Improvement Already Identified (Design)** 1.1 Consider whether: • the above identified areas for improvement should also be incorporated into the Audit Committee's Audit Action Tracker; or • the Audit Committee should receive an annual IG update covering progress against the IG workplan until all key actions are sufficiently implemented.	Medium	1.1 The Trust will provide updates to the Audit Committee on annual basis covering progress against the IG Workplan until all key actions are sufficiently implemented. This will ensure that Assurance in relation to progress is received quarterly by the Board via EMB and QSP Committee.	Matthew Bunce, Executive Director of Finance	Ian Bevan, Head of Information Governance	30th June 2023	Complete	Latest workplan progression reported to EMB on 2nd May 2023, report available for perusal by QSP on 16th May 2023 should they require it. On track to report from 30th June onwards as the new IG Toolkit will have been completed by that date which will inform the IG workplan for 2023-24.	Offline version of IG Toolkit 75% complete. The work is saving evidence in the relevant folder, uploading is a quicker task. Deadline remains 30th June 2023 which remains achievable.	IG Toolkit completed on time (30/6/23) and receipt confirmed by DHCW on the same day. Will inform the IG workplan for 2023/24 as previously briefed. Highest priority from the IG Toolkit remain the need to instigate and maintain Information Asset Registers across the Trust with training for Information Asset Owners. Estimated completion by 31st Mar 24.	n/a	n/a	n/a	Jul-23
Matters Arising 1	1.2 Include the development of the Records Management Strategy and SOP in the IG development plan.	Medium	1.2 The Trust has already included the development of the Records Management Strategy and SOP in the IG Development Plan, the latest report of which will be presented to the Integrated Quality and Safety Group on 14th March 2023.	Matthew Bunce, Executive Director of Finance	Ian Bevan, Head of Information Governance	Achieved	Action Closed	Noted as achieved on the report taken to the April 2023 Audit Committee.	n/a	n/a	n/a	n/a	n/a	May-23
Matters Arising 2	**Matter Arising 2: IG resource level (Design)** 2.1 Consider whether there is sufficient resources within the IG function to support its ongoing development and compliance with legislation.	Medium	2.1 The Trust will consider the subject of sufficient resources for the IG Function to support ongoing development and compliance with legislation. Due to the need to properly identify resources, the identified timeline takes account of need to conduct the assessment properly.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance (Senior Information Risk Owner (SIRO))	30th June 2023	Complete	For discussion between HOIG/SIRO - on track for delivery on 30th June 2023	HOIG focus is to assist recruitment of new FOIA Officer. This will free up resources to enable HOIG to focus on core elements of the tasksing. HOIG/SIRO will continue to discuss resources with aim of identfying those tha could support the IG function in 2023/24.	FOI Officer recruitment on TRAC, interviews planned for August 2023. DPO Funding confirmed as transferred from the DHCW SLA costs back to the Trust in June 2023. HOIG now taken over DPO role formally on behalf of the Trust in July 2023, this is confirmed by the ICO. The SIRO and DPO are exploring the use of the funding from the DHCW SLA to support resources for IG activity for the Trust.	n/a	n/a	n/a	Jul-23
Matters Arising 3	**Matter Arising 3: Mandatory IG Training uptake (Operation)** 3,1 Remind staff within the areas below the IG training compliance target: • to keep their mandatory IG training up to date; and • why it is important to do so. This could be achieved through corporate communications and line management structures.	Medium	3.1 The Trust has already addressed this recommendation via line management structures in an email to all Trust Directors on 3rd March 2023. In that email, the following communication was issued: *"The Trust has received a copy of the draft IG Internal Audit report, and whilst our Trust compliance figures are 85.98% as of 28th Feb 23, as you can see below, the divisional compliance data however is slightly different". (A copy of the compliance table was issued to Directors)* *"The minimal compliance figure is 75%3 (which is what the Audit report identified as the minimal baseline as well). To increase compliance levels, may I request that your teams complete their mandatory training on ESR. However, to try and assist, I am available for sessions to enable our Staff to complete their training in a face to face format if this is a better and easier approach, this can be bespoke or by joining pre-existing team meetings. There will of course be a competency check at the end of the session (pass mark 16/20) so that the Trust can be assured the training is delivering what it needs to in terms of ensuring our Staff have been trained properly".*	Matthew Bunce, Executive Director of Finance	Ian Bevan, Head of Information Governance	Achieved	Action Closed	Noted as achieved on the report taken to the April 2023 Audit Committee.	n/a	n/a	n/a	n/a	n/a	May-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

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 July 2023	Update August 2023	Update September 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 Colliandris, Head of Financial Planning & Reporting	30 November 2023	On Target	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.	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 has been scheduled for the beginning of Sep to review the procedure following significant changes following the Establishment of SCB.	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 udpate and review the procedure following significant changes following the Establishment of SCB.			n/a	
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	Complete			**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.				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	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	Complete	Action Open: Draft terms of reference have been completed in line with timelines. These are due to be considered for approval in August 2023 by the Trust Executive Management in line with the agreed governance arrangements.		**Complete.** Terms of reference for the capital planning group have been reviewed and refreshed e.g. removing Carl James and Matthew Bunce as membees / chair / deputy chair and replaced by Phil Hodson and Steve Colliandris. These were approved by the Capital Planning Group on 8th August 2023.	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	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			n/a	n/a	n/a	

Audit Action Plan

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

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

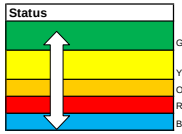
* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Follow Up: Previous Recommendations - 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 August 2023	Update September 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	On Target		*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.		n/a	n/a	
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	Complete	Presentation on the Audit Action Tracker Procedure added to the Agenda for VCC SLT Part 2 on the 20th September 2023. Email exchange is also in process for a presentation at a WBS meeting.	**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 - Reasicic target dates reminder; Completed - Extension request frequency column added to tracker	Complete	Column 'Extention Request Total' has now been added to the Audit Action Tracker	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	Complete	n/a	n/a		n/a	n/a	Jul-23
BCC 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	On Target				n/a	n/a	
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	Complete	n/a	n/a		n/a	n/a	Jul-23

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

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 August 2023	Update September 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	On Target		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.		n/a	n/a	
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	On Target		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.		n/a	n/a	
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	On Target		These discussions will be held during the developing IMTP meeting on 27.09.2023.		n/a	n/a	
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.		n/a	n/a	

Archwilio Cymru
Audit Wales

Audit Committee Update – Velindre University NHS Trust

Date issued: October 2023

Document reference: ACU202310

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 We will liaise with the Trust to confirm the likely date of receipt the of the Trust's charitable funds 2022-23 accounts and the related timing of our audit.

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 remaining work				
Local study - Operational Governance	To be confirmed	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
Workforce planning	Director of Corporate Governance and Chief of Staff/ Executive Director of	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	**Report in clearance** Draft sent to the Trust for clearance on 30 August.	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
	Organisational Development & Workforce			
2023 Audit Plan				
Structured Assessment	Director of Corporate Governance and Chief of Staff	A review of the corporate arrangements in place at the Trust in relation to: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	**In progress** Fieldwork is underway, with reporting by the end of October 2023	To be confirmed
Structured Assessment Deep Dive - Digital	Executive Director of Strategic Transformation,	Review of digital arrangements, with a focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce,	**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
	Planning and Digital	transform patient care, meet demand, and improve productivity and efficiency.		
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
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
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Digital inclusion in Wales	March 2023

Additional information

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

Exhibit 3 – Audit Wales corporate documents

Title	Publication Date
Biodiversity and Resilience of Ecosystems Plan for Audit Wales 2023 – 2027	**August 2023**
Annual Report and Accounts 2022-2023	June 2023
Audit Wales Annual Plan 2023-24	March 2023

9 The consultation on Fee Scales for 2024-25 is open until 10 October 2023.

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Audit of Accounts Report Addendum– Velindre University NHS Trust

Audit year: 2022-23

Date issued: October 2023

Document reference: 3830A2023

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

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

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

Contents

Audit of accounts report addendum

Introduction

1 This report is an addendum to our Audit of Accounts Report that we presented to the Audit Committee and Trust Board on 26 and 27 July 2023. The report sets out a small number of additional recommendations arising from our audit of the 2022-23 accounts to those that were raised in the Audit of Accounts Report. The report also provides an update on the progress the Trust has made upon our previous years' recommendations.

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

Recommendations from this year's audit

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

Exhibit 1: Matter Arising 1

The majority of declaration of interest returns were completed in January or February rather than at the year end	
Findings	As communicated within our Audit Plan we consider the Trust's Related Party Transaction disclosures to be material by nature and so set a much lower materiality threshold. We found that twelve of the fifteen declaration of Interest returns completed by Board Members and used for the production of the related parties note were completed in January or February 2023 rather than at the year end. Although Board Members are required to provide updates should their interests change, there remains a risk that the related parties note is not based on complete or accurate information.
Priority	High
Recommendation	Declaration of Interest returns should be competed as close to the year end as possible or if completed before the year end, officers should confirm in writing that there have been no changes.

The majority of declaration of interest returns were completed in January or February rather than at the year end	
Benefits of implementing the recommendation	Returns completed prior to the year end could be incomplete as these may not capture any changes of interests that have occurred before the year end.
Accepted in full by management	Partial
Management response	Declarations of interest could not be requested in late March /early April (as per recommendation) as this would fall at the end of the Financial Year when a number of Trust Officers take Annual Leave before the end of the Financial Year as it falls over the Easter period. This would prevent a complete return from being received in time to enable the necessary due diligence to be undertaken by Finance and Governance Leads when assessing returns for any impact to the Trust financial accounts/statements, in readiness for submission of the First Draft of the Trust Accounts each year. Trust Officers note their obligation to inform the Trust should there be any changes to their declaration on submission in accordance with the established due process. As such, the Trust is content that should there be any changes in the few weeks prior to the end of year from the date of return that this would then be reported as such. Declarations of Interest Returns for the next financial year will be requested at the end of February 2024, with a further request made to Board members in late March 2024 to confirm in writing that there have been no changes.
Implementation date	31st March 2024

Matter Arising 2

Errors were identified in the accruing of costs relating to the enabling works for the new Velindre Cancer Centre	
Findings	Our testing of the £1.1m capital accrual in relation to the enabling works for the new Velindre Cancer Centre identified elements of the accrual which were either not supported or duplicated spend already incurred. These were: • £0.315m relating to compensating events already paid in year; and • £0.080m relating to an unspecified contingency Our testing of other accruals across the Trust did not identify any similar errors and so have no evidence to suggest that there is a pervasive risk across the Trust that accruals are overstated.
Priority	Medium
Recommendation	Any significant capital accruals should be reviewed to ensure they are valid accruals and can be fully supported.
Benefits of implementing the recommendation	Accurate reporting of capital expenditure and accruals
Accepted in full by management	Yes
Management response	The nVCC Project notes the comments raised by the external auditors and accept the points raised. The nVCC Project will ensure more accurate reporting from its Advisors so as to ensure that the project costs reflect a more accurate financial position.
Implementation date	31st March 2024

Matter Arising 3

Weaknesses were identified in the presentation of inter NHS income and expenditure within the accounts	
Findings	In previous audits we have raised shortcomings in the coding of transactions to identify inter Welsh NHS and Welsh Government transactions (NHS Matrix transactions) in the ledger. This can result in potential errors in the categorisation of income and expenditure in the notes to the financial statements. In response to our previous recommendation, the Trust changed the way in which these transactions were categorised in the accounts. This was not our intention from our recommendation. The Welsh Government subsequently rejected this new categorisation and required the Trust to re-do the relevant notes to the financial statements. Whilst the Trust actioned this request and the presentation was materially correct there were still in our view some uncertainties within the disclosures and so the risk of categorisation errors remains present.
Priority	Medium
Recommendation	To support the accuracy of the income and expenditure disclosures, the Trust should revisit their approach to identifying the agreed transactions with Welsh NHS Bodies and Welsh Government so that a suitable audit trail provided to support the disclosure notes and the FRS6 return to the Welsh Government.
Benefits of implementing the recommendation	Accurate reporting of inter Welsh NHS and Welsh Government transactions in the income and expenditure notes in the financial statements.
Accepted in full by management	Yes

Weaknesses were identified in the presentation of inter NHS income and expenditure within the accounts	
Management response	We will revisit our approach to identifying the agreed transactions with Welsh NHS Bodies and Welsh Government. This will include continuing to build on the work to improve the coding of transactions in the financial ledger and reminding colleagues to ensure that the transactions are coded to the appropriate codes.
Implementation date	31st March 2024

Recommendations from previous years' audits

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

Exhibit 2: progress against previous year's recommendations

Audit Year	Recommendation	Progress
2021-22	Note 26.3 within the Trust's Financial Statements should include losses relating to Structured Settlement cases and discussions should be held with Welsh Government for the prior year figures to be restated.	Addressed in full
2021-22	We recommend that those officers posting transactions are reminded of the need to use the appropriate coding so that inter Welsh NHS and Welsh Government can be accurately disclosed in the accounts	Not adequately addressed. See recommendation 2 above within **Exhibit 1**

Audit Wales

24 Cathedral Road

Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

Archwilio Cymru
Audit Wales

Review of Workforce Planning Arrangements – Velindre University NHS Trust

Audit year: 2023

Date issued: August 2023

Document reference: 3684A2023

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

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

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

Once this report is finalised, this document will also be available in Welsh.

Contents

Summary report

Introduction

1 An effectively planned workforce is fundamental to providing good quality care services. The NHS employs a range of clinical and non-clinical staff who deliver services across primary, secondary and community care, representing one of the largest NHS investments. Over the years there have been well documented concerns about the sustainability of the NHS workforce. And workforce challenges are routinely highlighted to us in our audit reviews and ongoing engagement with health bodies. Despite an overall increase in NHS workers, these concerns remain. The workforce gaps are particularly acute for certain professions such as GPs, nurses, radiologists, paediatricians and ophthalmologists (A Picture of Healthcare, 2021). In nursing alone, the Royal College of Nursing Wales reported 2,900 vacancies in their 2022 Nursing in Numbers analysis. In addition, the social care sector, which is complimentary to the health sector, is also facing its own workforce issues. These challenges have been exacerbated by the pandemic as the health sector looks to recover services.

2 Given the current challenges, robust and innovative workforce planning is more important than ever. Effective workforce planning ensures that both current and future services have the workforce needed to deliver anticipated levels of service effectively and safely. Planning is especially important given the length of time required to train some staff groups, particularly medical staff.

3 National and local workforce plans need to anticipate service demand and staffing levels over a short, medium, and long-term. But there are a range of complex factors which impact on planning assumptions, these include:

- workforce age profile, retirement, and pensions taxation issues.
- shifts in attitudes towards full and part time working.
- developing home grown talent and the ability to attract talent from outside the country into Wales.
- service transformation which can change roles and result in increasing specialisation of roles.

4 Velindre University NHS Trust (the Trust) provides specialist services across Wales. The operational delivery of services is managed through two divisions, Velindre Cancer Service and the Welsh Blood Service. The Trust's 10-year People Strategy, Employer of Choice - Helping Each Other Be Great (the People Strategy), was approved by the Board in May 2022. The People Strategy is one of a suite of enabling strategies underpinning the Trust's corporate strategy, Destination 2032.

5 The key focus of our review has been on whether the Trust's approach to workforce planning is helping it to effectively address current and future NHS workforce challenges. Specifically, we looked at the Trust's strategic approach to workforce planning, operational action to manage current and future challenges, and monitoring and oversight arrangements. Operational workforce management

arrangements such as staff/nurse rostering, consultant job planning and operational deployment of agency staffing, fall outside the scope of this review.

6 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

7 Overall, we found **that the Trust is strengthening its strategic workforce planning supported by improving workforce intelligence. However, it lacks sufficient oversight on the impact of its workforce initiatives and needs to ensure it has the capacity and capability to deliver longer term workforce priorities**.

Key workforce planning challenges

8 At the time of writing this report, the key workforce issues at the Trust related to filling vacancies for professions in areas with longstanding national challenges. Vacancy levels, for the period that we collected data, were higher than average across Wales, with some notable gaps including consultant radiologists, acute oncology consultants and medical physicists[1] and some nursing roles. The Trust is still dealing with the effect of the pandemic with high sickness in some service areas. Spending on agency staff increased considerably in 2020-2021 to £2.7 million but has since fallen to £1.3 million in 2022-23 (**Exhibit 6**). The Trust is currently building a new Velindre Cancer Centre, this provides opportunities to develop new workforce models.

Strategic approach to workforce planning

9 **The Trust has a reasonably good workforce strategy but, it needs to be underpinned by a robust delivery plan, supported by service modelling.**

10 The Trust has a clear strategic vision for its workforce however, to effectively deliver it, it needs to develop its strategic workforce planning approaches and develop an underpinning implementation plan. The Trust has a reasonable understanding of its current service demands, based on its current service models. It is working well with internal and external stakeholders to find shared solutions to workforce challenges. However, there is scope for the Trust to strengthen its analysis of anticipated future demands to shape future workforce requirements and inform workforce modelling. The Trust is currently working on this, and the position should improve once the Trust has finalised its Supply and Shape Framework[2], which it expects to complete in September.

[1] Medical Physics is the application of physics to medicine. It uses physics concepts and procedures in the prevention, diagnosis, and treatment of disease.

[2] The framework will include workforce analysis and service modelling, including scenario and service change mapping. There are six principles to model the workforce, these are: 1. Resource and Replenish (Buy), 2. Redevelop and Reskill (Build), 3. Reposition and Renew (Borrow), 4. Retain and Reward (Bind), 5. Resolve and Revive (Bounce) and 6. Rediscover and Reinvent (Boost).

Operational action to manage workforce challenges

11 **The Trust is taking some positive action to manage current and future workforce challenges but recognises it is in the early stages of developing a more robust and effective approach to workforce planning.**

12 The Trust has clear intent to improve workforce planning capacity and capability. However, limited corporate capacity and operational pressures mean that service leads do not have sufficient time to develop workforce planning solutions to help address operational challenges. The Trust understands high-level workforce risks associated with delivering its People Strategy, but actions to mitigate these risks have had minimal effect to date. The development of the Supply and Shape Framework should also help to identify workforce gaps and inform future corporate risk assessment. The Trust is taking steps to help it respond to current workforce challenges through a range of recruitment and retention activities.

Monitoring and oversight of workforce plan/strategy delivery

13 **Whilst Board and committee maintain reasonable oversight of workforce challenges, there needs to be stronger focus on the extent that actions are having an impact on reducing short and medium-term workforce risks.**

14 Whilst the Quality, Safety and Performance Committee receives timely workforce performance reports, the Trust needs to strengthen how it reports on the impact of the People Strategy's delivery i.e., what difference it is making. Where possible the Trust benchmarks its workforce performance with other health bodies in Wales and networks with comparing organisations across the UK.

Recommendations

Exhibit 1: recommendations

15 **Exhibit 1** details the recommendations arising from this audit. These include timescales and our assessment of priority. The Trust's response to our recommendations is summarised in **Appendix 3**. [Appendix 3 will be completed once the report and organisational response have been considered by the relevant committee.]

Recommendations
Developing an implementation plan R1 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**).
Developing workforce intelligence R2 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**).
Managing risk R3 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**).
Exit surveys

Recommendations

R4 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)**.

Education commissioning process

R5 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**).

Monitoring and oversight

R6 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**).

Detailed report

Our findings

16 The following three tables set out the areas that we have reviewed and our findings. These focus on:

- The Trust's approach to strategic workforce planning (**Exhibit 2**).
- Operational action to manage workforce challenges (**Exhibit 3**).
- Monitoring and oversight of workforce plan/strategy delivery (**Exhibit 4**).

Exhibit 2: The Trust's approach to strategic workforce planning

This section focusses on the Trust's approach to strategic planning. Overall, we found that **the Trust has a reasonably good workforce strategy, but it needs to be underpinned by a robust delivery plan, supported by service modelling.**

What we looked at	What we found
We considered whether the Trust's workforce strategy and plans are likely to address the current and future workforce risks. We expected to see a workforce strategy or plan which: • Identifies current and future workforce challenges. • Has a clear vision and objectives. • Is aligned to the organisation's strategic objectives and wider organisational plans.	We found **the Trust has a clear workforce vision and strategy. However, it does not yet have a sufficiently mature supporting implementation plan to address its current and future workforce challenges and opportunities.** The Trust's 2022-32 People Strategy clearly sets out the Trust's ambition to be an 'employer of choice'. To help achieve its ambition, the People Strategy focuses on six key priorities, these being: workforce engagement, workforce modelling, workforce development, leadership and succession planning, a digital ready workforce, and recruitment and retention. While not explicitly identifying the Trust's workforce challenges, these priorities seem logical given the workforce challenges it faces. The Trust's division level strategies for Velindre Cancer Service and the Welsh Blood Service highlight some key workforce challenges and opportunities. The People Strategy appropriately

What we looked at	What we found
• Is aligned to relevant national plans, policies, and legislation. Including the national workforce strategy for health and social care. • Is supported by a clear implementation plan.	supports the ambitions set out in the national Workforce Strategy for Health and Social Care[3] and aligns to relevant legislation, such as the Wellbeing of Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014. It also supports the delivery of the Trust's long-term ambitions as set out in its corporate strategy, Destination 2032 and its Integrated Medium-Term Plan (IMTP). The People Strategy does not have a standalone implementation plan to support its delivery, instead actions are included in the Trust's 2023-2026 IMTP. However, the actions are at a high-level and provide little detail about how the Trust plans to implement the ambitions set out in the strategy or measure the impact of its delivery (**Recommendation 1**). The Trust recognises that it needs to strengthen its implementation plans.
We considered whether the Trust has a good understanding of current and future service demands. We expected to see: • Use of reliable workforce information to determine workforce need and risk in the short- and longer-term. • Action to improve workforce data quality and address any information gaps.	We found that **the Trust has a reasonable understanding of its current service demands, based on current service models, but there is scope to strengthen future demand modelling to inform future workforce requirements.** The Trust is looking to improve its workforce intelligence by developing an ambitious Supply and Shape Framework[4]. This Framework will be presented to the Executive Management Board in September. Once finalised, this Framework should enable the Trust to appropriately identify its workforce gaps. The Corporate Planning Team has initially undertaken horizon scanning exercises[5] to inform the Supply and Shape Framework. This will help to provide a stronger basis to predict future service need and shape future workforce requirements. Currently, demand and capacity planning at the Trust is inconsistent, with different methods used by the divisions. The Welsh Blood Service has an agile approach based on data from its Business

[3] 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' is a 10-year strategy was launched in October 2020 by us (HEIW) and Social Care Wales

[4] The framework will include workforce analysis and service modelling, including scenario and service change mapping. There are six principles to model the workforce, these are: 1. Resource and Replenish (Buy), 2. Redevelop and Reskill (Build), 3. Reposition and Renew (Borrow), 4. Retain and Reward (Bind), 5. Resolve and Revive (Bounce) and 6. Rediscover and Reinvent (Boost).

[5] Using NICE guidelines, Macmillan index, Population Health Assessments, and information from Commissioners

What we looked at	What we found
	Intelligence Service, whilst Velindre Cancer Service uses a predictive model based on pre-pandemic baseline data and data from a recent exercise with commissioners[6]. There are merits to both models, with opportunities for the divisions to share learning and for the Trust to use these tools to build and maintain its supply and shape framework **(Recommendation 2)**. The Trust has reasonable operational workforce data, such as sickness levels, vacancy and appraisals rates which are sourced from the Electronic Staff Record system (ESR). However, in some instances the quality and consistency of certain metrics could be improved. For example, whilst there is an agreed funded establishment[7], we understand that financial data and workforce data do not always align. The Trust is taking steps to improve data quality, as some of these issues are common across NHS Wales. The Trust is involved in appropriate national working groups to find shared solutions such as the All-Wales Data Quality Group. The Trust is also taking steps to improve service-level access to workforce data using management dashboards.
We considered whether the Trust is working with partners to help resolve current and anticipated future workforce challenges. We expected to see: • Effective and timely engagement and working with key internal and external stakeholders to tackle current and future workforce issues.	We found that **the Trust is engaging well with internal and external partners to find shared solutions to address current workforce challenges.** Within the organisation, the Workforce Planning Manager and HR Business Partners engage well with the Trust's service leads. They provide workforce planning training and support service level workforce plan development. However, there are some constraints. We understand that due to service pressures, service level engagement in workforce planning can be variable. The Trust has a good understanding of issues affecting its workforce and their wellbeing. There are with good arrangements to hear from staff-side representatives and good relationships with trade

[6] Health boards in South-East Wales commission specialist cancer services from Velindre Cancer Service.

[7] Establishment is the term for the workforce levels, staff roles and the NHS Agenda for Change banding which is financially budgeted for.

What we looked at	What we found
• Shared solutions identified with key stakeholders to help address workforce challenges.	unions through the Local Partnership Forum. This helps to target its HR workforce initiatives with an aim of tackling workforce challenges, for example where staff sickness and staff turnover is high. Externally, the Trust recognises the importance of working with regional partners to support the development of sustainable services. We found positive examples of the Trust working in collaboration to address current workforce gaps. For example, a joint appointment with Cardiff and Vale University Health Board of a medical physicist for the regional programme on acute oncology service. In addition, there are several regional transformation projects at various stages, which have workforce implications and will need workforce modelling and plans. These include designing a paperless working environment at the new Velindre Cancer Centre, a new Radiotherapy Satellite Centre at Neville Hall Hospital and modernisation of Welsh Blood Service laboratory in Talbot Green. Velindre Cancer Service has also linked in with other cancer centres across the UK and undertook a peer review with Clatterbridge Cancer Centre. The Trust's also engages well with Health Education Improvement Wales (HEIW) and has co-opted a HEIW representative to the Trust's Education Steering Group[8]. We saw evidence of open and honest discussions between the Trust and key stakeholders on challenges such as the decision to stop the streamlining process for radiography[9] as it was not addressing immediate workforce shortages.

[8] The Group's remit is to: identify areas of priority for educational intervention through the IMTP and strategic operational plans and monitor and agree work plans; agree KPI's for work plans and hold to account; support Divisions to provide detailed plans for educational support; and be accountable for equitable and allocation of educational spend.

[9] The Student Streamlining Scheme was developed by NHS Wales Shared Service Partnership, in agreement with NHS Wales Health Bodies and Universities across Wales and is a matching process meaning Student Nurses and Allied Health Professions & Healthcare Science graduates do not need to submit multiple applications via NHS Jobs to secure their first job in NHS Wales after graduating.

Exhibit 3: Operational action to manage workforce challenges

This section focusses on the actions the Trust is taking to manage workforce challenges. Overall, we found that **the Trust is taking some positive action to manage current and future workforce challenges but recognises it is in the early stages of developing a more robust and effective approach to workforce planning.**

What we looked at	What we found
We considered whether the Trust has identified sufficient resources to support workforce planning over the short, medium and long-term. We expected to see: • Clear roles and responsibilities for workforce planning. • Appropriately skilled staff to ensure robust workforce planning. • Sufficient workforce capacity across the organisation to plan and deliver the workforce strategy or plan. • Sufficient financial resources to deliver the workforce strategy or plan.	We found that **the Trust has clear intent to improve workforce planning capability but should ensure it has the resources to support the delivery of its People Strategy** Corporately, roles and responsibilities for workforce planning are clear within the People and Organisational Development team. The Trust appointed a permanent Workforce Development Manager earlier this year, although only part of the Workforce Development Manager's role is dedicated to workforce planning. Similarly, the two corporate human resources business partners that support directorates' workforce planning also deal with operational HR matters. This limited capacity may inhibit the extent that the corporate team can help services plan for their current needs and modernise services. At an operational level, our fieldwork identified that service leads generally understood their role in workforce planning. However, service managers indicated that service pressures did not allow them sufficient thinking time to develop solutions. This is resulting in a varying degree of service-level involvement in workforce planning. The Trust recognises the need to develop managers capability across the organisation and has started rolling out workforce planning training. Historically, workforce planning within the Trust was ad-hoc and informal. As a result, the Trust does not yet have a clear picture of its skills gap and how it affects the quality of workforce planning. The People and Organisational Development team have

What we looked at	What we found
	developed and is delivering training modules alongside a toolkit based on HEIW's six step model[10] which is being well received. The Trust's People Strategy is costed as part of its annual IMTP development process however, this does not allow it to identify the longer-term workforce costs, skills or other resources associated with delivering it over a longer period. Whilst the Trust is working in a challenging financial environment, at the time of writing this report, it does not currently require its Directorates to hold vacancies to meet savings targets. However, we understand that the Trust appointed staff in both directorates at risk in response to the pandemic[11]. It also recruited to support some service developments without agreed permanent ongoing funding. Given the financial pressures across Wales, there may be a need to reassess this position as part of its wider financial planning.
We considered whether the Trust has a good understanding of the short- and longer-term risks that might prevent it from delivering its workforce strategy or plan. We expected to see: • A good understanding of the barriers that might prevent delivery of the workforce strategy or plan. • Plans to mitigate risks which may prevent the organisation from achieving its workforce ambitions. • Clearly documented workforce risks that are managed at the appropriate level.	We found that **whilst the Trust understands high-level workforce risks associated with delivering its People Strategy, actions to mitigate these risks have had minimal effect to date.** The Trust's workforce ambitions are articulated in its People Strategy, but there are a range of risks which may prevent its delivery. These mainly relate to service pressures such as increased demand, workforce shortages and financial pressures. High-level workforce risks are appropriately reflected and managed through the Trust's Assurance Framework and corporate risk register. However, the scale of the workforce challenges mean that mitigating actions are having minimal effect on reducing workforce risks. Some of the arrangements to manage these risks are relatively new and once embedded and if successful, may help reduce some workforce challenges. These include the work of the Attraction, Retention and Recruitment Programme Group, Healthy and Engaged Steering Group and the hybrid working project. In addition, the development of the Supply and Shape Framework will provide the Trust with a clearer picture of current workforce capacity and challenges and may identify new workforce risks, such as risks associated with meeting future service demand (**Recommendation 3**).

[10] Health Education and Improvement Wales has developed a workforce planning toolkit based on the following six steps: 1, Define your plan, 2. Map the service change, 3. Define the workforce, 4. Workforce supply, 5. Define actions required, 6 Implement and monitor.

[11] At the time of appointment, these posts were funded by supplementary funding from the Welsh Government to cover the additional pressures arising from the pandemic, but it was not clear how they would be funded once the supplementary funding ceased.

What we looked at	What we found
We considered whether the Trust is effectively addressing its current workforce challenges. We expected to see: • Effective reporting and management of staff vacancies. • Action to improve staff retention. • Efficient recruitment practices. • Commissioning of health education and training which is based on true workforce need. • Evidence that the organisation is modernising its workforce to help meet current and future needs.	We found that **the Trust is taking appropriate steps to address current workforce challenges at an operational level through a range of recruitment, retention, and development activities.** As a percentage of its total establishment, the Trust has one of the highest vacancy rates compared to other health bodies in Wales (**Exhibit 7**), as such, the Trust is addressing this workforce gap through overtime arrangements and increasing its use of agency staff. The corporate workforce team provide targeted support to services where the data highlights particular hot spots such as high vacancy rates. Spend on agency staff increased considerably in 2020-21 to £2.7 million but has since reduced to £1.3 million in 2022-23 (**Exhibit 6**). The Trust is starting to take positive action to improve staff retention and build workforce resilience. For example, by offering some bank staff, specifically administrative and facilities staff and flexible working options. The Trust has also reduced nursing and health care support worker vacancy rates in Systemic Anti-Cancer Therapy (SACT)[12] through targeted recruitment interventions. However, as with other parts of the NHS, there are longstanding gaps in parts of the workforce which the Trust will need to manage. We noted specific staffing pressures for consultant radiologists, acute oncology consultants and medical physicists[13] and some nursing roles. The Trust is still dealing with the effect of the pandemic with high sickness in some service areas. The Trust does not include details on staff turnover in its performance report making it difficult for the organisation to get a clear view if this is improving or deteriorating. The Trust uses exit surveys to

[12] Systemic Anti-Cancer Therapy is any drug treatment used to control or treat cancer. The drug treatment types may include chemotherapy, immunotherapy, targeted therapy, hormonal therapy or a combination of these.

[13] Medical Physics is the application of physics to medicine. It uses physics concepts and procedures in the prevention, diagnosis, and treatment of disease.

What we looked at	What we found
	understand the underlying reasons behind staff turnover but could do more to actively encourage staff to complete surveys and analyse their responses (**Recommendation 4**). At 6.3% in 2021-22, the Trust's sickness absence figures are just under the NHS Wales average of 6.9%. Like most other NHS bodies in Wales, it does not meet the Welsh Government's target of 3.54% (**Exhibit 8**). To help address this, the Trust has established its Healthy and Engaged Steering Group that is focussing on improving how staff are supported and valued. The Trust places a great emphasis on staff wellbeing. This is demonstrated in Board and Committee discussions. Staff also have access to a range of physical and mental wellbeing offers, financial support and flexible working, where business needs allow. The Trust is strengthening its recruitment approaches. The Trust's recruitment process is managed by NHS Shared Services Partnership. However, recognising there are inefficiencies in its internal process, the Trust has made some improvements. These include, agreeing a standardised Trust recruitment policy. This strengthens arrangements for recruiting timeliness and joined-up service and corporate recruitment processes. In collaboration with NHS Share Services Partnership, the Trust has already improved candidate on-boarding time reducing this from 113.5 days in June 2022 to 70.4 days in March 2023. The Trust has also developed recruitment videos for the Welsh Blood Service, attends recruitment fairs to promote the Trust with school, colleges and universities and is developing targeted recruitment campaigns through social media. The Trust is working on improving the basis of its education commissioning and has recently strengthened the process, which is now overseen by the Education Steering Group. Education commissioning numbers are now aligned to the IMTP. However, it needs to triangulate the number of staff it trains through the education commissioning process and how many it then employs (**Recommendation 5**). In recent years the Trust has been seeking alternative solutions to ensure a sustainable workforce. For example, focusing on grow your own schemes and ensuring staff operating at the top of their licence[14]. The Trust is also exploring ways to change the skills mix for various fragile services by exploring the use of new roles such as physicians' associates, advances practitioner nurses and various assistant and technologist roles, but progress is, as yet, limited.

[14] Operating at the top of license means each employee practices to the full extent of their education and training, instead of spending time doing tasks that could be performed by someone else.

Exhibit 4: Monitoring and oversight of workforce plan/strategy delivery

This section of the report focusses on the robustness of corporate oversight of workforce risks. We found that **whilst Board and Committee maintain reasonable oversight of workforce challenges, there needs to be stronger focus on the extent that actions are having an impact on reducing short and medium-term workforce risks.**

What we looked at	What we found
We considered whether delivery of the Trust's workforce strategy or plan is supported by robust monitoring, oversight, and review. We expected to see: • arrangements in place to monitor the progress of the workforce strategy or plan at management and committee levels. • effective action where progress on elements of the workforce strategy or plan are off-track. • Performance reports showing the impact of delivering the workforce strategy or plan. • The organisation benchmarking its workforce performance with similar organisations.	We found **that whilst there is a reasonable monitoring and oversight of the delivery of key People Strategy actions, the Quality, Safety and Performance Committee and Senior Management need better information on impact that strategy delivery is achieving.** The Quality, Safety and Performance Committee is responsible for scrutinising workforce matters which includes delivery against the People Strategy. At its recent meeting in July 2023, it received an update on the first year of the People Strategy's delivery. While the report is clearly showing progress on key actions, there is currently insufficient analysis on whether the actions are having the desired impact. It could have, for example, made the link to highlight where key workforce metrics changed as a result of strategy action delivery. As highlighted earlier in this report, the IMTP acts as a high-level implementation plan supporting the Trust's People Strategy, but we found the quarterly IMTP performance report has not included any updates against the workforce and organisational development priorities since quarter 1 and 2 reports of the 2022-2025 IMPT. Therefore, this again makes it difficult for the wider Board to understand whether the Trust is successfully delivering its strategic workforce ambitions. As the update on the first year of the People Strategy's delivery focused mainly on delivery against milestones this impedes the Quality, Safety and Performance Committee's ability to effectively scrutinise the impact that strategy delivery is achieving. (**Recommendation 6**). Directorate's Senior Leadership Team receive monthly workforce dashboards allowing them to scrutinise performance such as sickness, vacancy and data on recruitment. Management then take

action for the month ahead where performance is off track. The Trust's workforce steering groups, as mentioned above, submit quarterly highlight reports to the Executive Management Team but our fieldwork found that these concentrate on short-term actions and do not adequately consider the impact of the work undertaken.

Where possible, the Trust benchmarks its workforce performance with other health bodies in Wales, comparing metrics such as turnover, sickness rates and time to hire. The Welsh Blood Service is an active part of UK wide, Europe and further afield comparator networks.

Audit methods

Exhibit 5 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

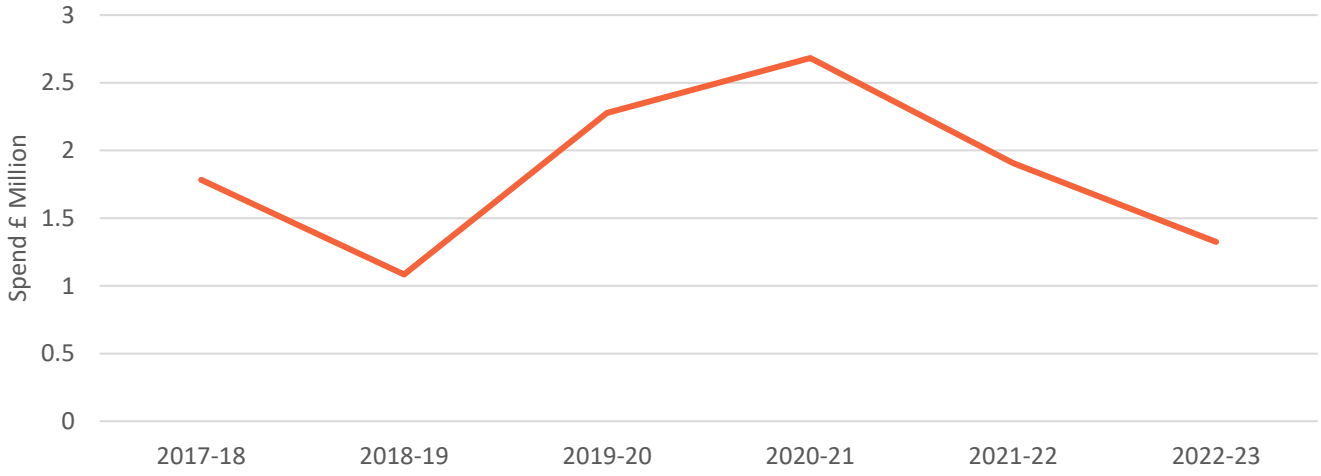
Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Workforce strategy and associated workforce plan(s) • Integrated Medium-Term Plan • Evidence of evaluation of workforce strategy and / or associated initiatives • Information feeding into workforce strategy development e.g., needs assessment, workforce data, benchmarking exercises, demand and capacity planning, skills gap analysis, horizon scanning • Evidence of stakeholder engagement • Structure charts for workforce planning functions • Examples of workforce planning training offered to staff e.g., CIPD, other training formal or informal • Workforce finance and resource plans • Corporate and operational risk registers • Document showing recruitment process and recruitment and retention initiatives • Corporate and operational level oversight and monitoring of workforce metric and strategy delivery
Interviews	We interviewed the following: • Chair of Quality, Safety & Performance Committee • Deputy Director for Workforce and OD • Director of Welsh Blood Service

Element of audit approach	Description
	• Medical Business Manager • Executive Director for OD & Workforce • Workforce Information Manager • Workforce Planning Manager • Head of Workforce • Deputy Director Finance • Divisional Senior OD Business Partners x 2 • Executive Director of Nursing, Allied Health Professionals and Health Science • Director of Welsh Blood Service • Chief Operating Officer

Appendix 2

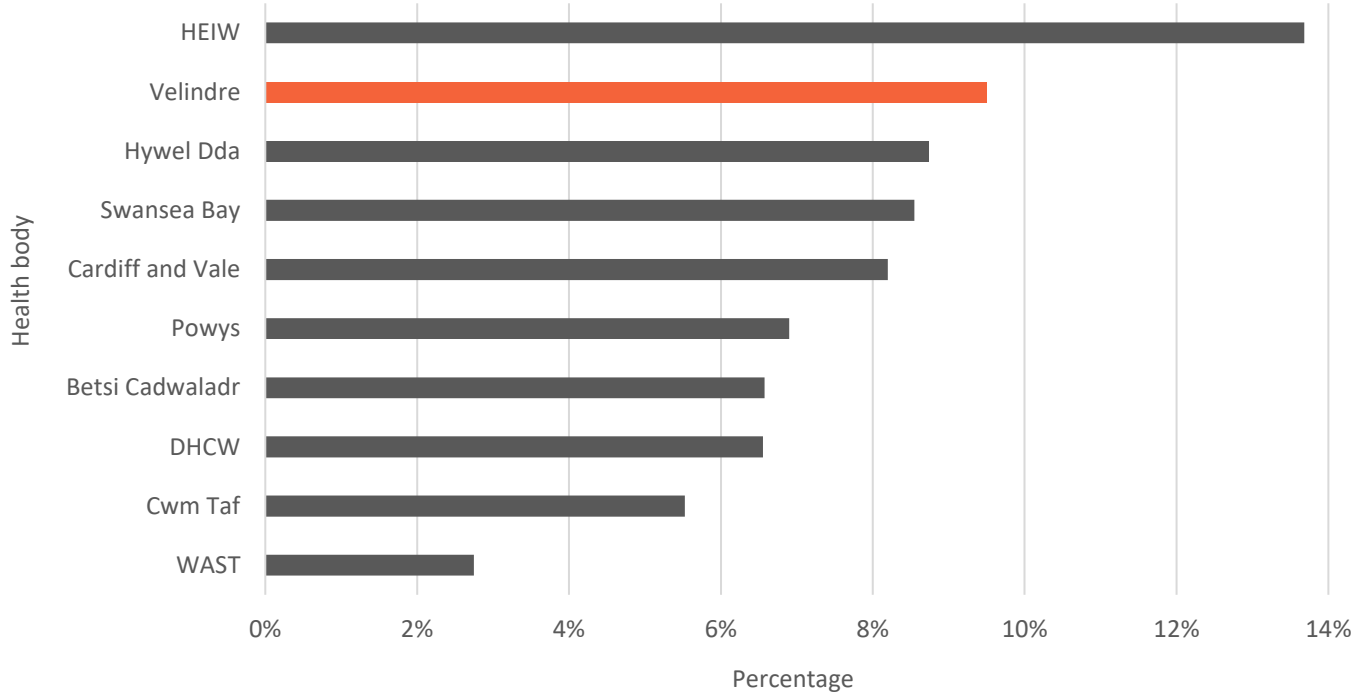
Selected workforce indicators

Exhibit 6: Trend of expenditure on workforce agency (Excluding NWSSP agency costs)



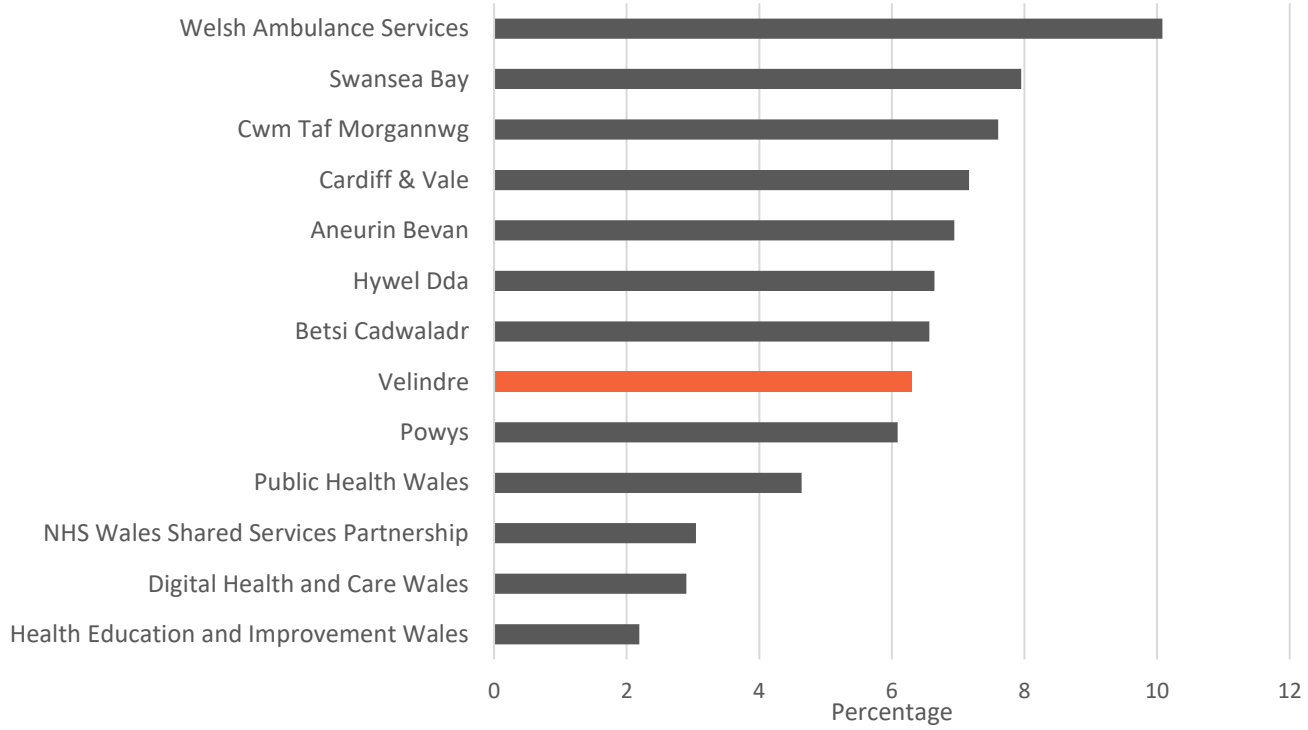
Source: Monthly Monitoring Returns reported to Welsh Government

Exhibit 7: Vacancies as a percentage of total establishment, as of March 2022



Source: health body data request

Exhibit 8: Percentage sickness absence by organisation, 2022



Source: Welsh Government, Stats Wales

Appendix 3

Organisational response to audit recommendations

Exhibit 9: Velindre University NHS Trust response to our audit recommendations.

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R1	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**).	An implementation plan for the Strategy has been developed which highlights risk and governance arrangements.	September 2023	Susan Thomas Deputy Director of WOD
R2	The Trust should develop a consistent approach to model future service demand to understand the longer-term human and financial resource implications and	A Supply and Shape governance group is being established to provide governance and accountability regarding the completion of workforce plans across the Trust:	First Workshop in November 2023 A full project plan to be developed	Susan Thomas

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
	potential risks to the organisation (**medium priority**).	• to understand the current workforce programmes; • to understand the collective priorities in the programmes; • to agree the alignment between collective priorities - joining up and aligning initiatives; and • to 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.	following the November session	Deputy Director of WOD
R3	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	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	The TAF is due to Trust Board on 28th September	Sarah Morley Exec Director of WOD

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
	additional sources of assurance and new risks (**high priority**).	and the Executive Management Board. The new template has been developed, taking into consideration Trust-wide frameworks.	2023 for approval.	
R4	The Trust should develop an approach to increase exit survey response rates and ensure feedback feeds into retention activities **(medium priority)**.	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;	December 2023	Amanda Jenkins Head of Workforce

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
		• streamlined, digital process, rendered for easy access mobile use, utilising current technology; and • paperless process reduces risk.		
R5	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**).	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.	March 2024	Susan Thomas Deputy Director of WOD

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)
R6	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**).	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.	March 2024	Susan Thomas Deputy Director of WOD

Archwilio Cymru
Audit Wales

Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

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

AUDIT COMMITTEE

INTERNAL AUDIT PROGRESS UPDATE REPORT

DATE OF MEETING	5th October 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	Emma Rees, Deputy Head of Internal Audit
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
APPROVED BY	Matthew Bunce, Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to set out progress against the 2023/24 Annual Internal Audit Plan and key performance indicators.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to **NOTE** the content of the progress update report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Shape	18/09/23

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

We provide a progress report to the monthly EMB Run meeting (Shape in this case, as we also covered 24/25 planning). We attend the meeting to present the report approximately quarterly, and the report is on the consent agenda for noting when we are not in attendance.
 	
On 18/09/23:
• we discussed the timeliness of management responses:
  ○ presented an analysis of management response timeliness;
  ○ highlighted action taken to improve this; and
  ○ requested EMB identify any further action required.
• we set out the timetable for 2024/25 annual planning and requested EMB considers areas for inclusion in the plan. We will attend EMB Shape again in November 2023 for further discussions on this.

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Not applicable for this report (for noting / information)

APPENDICES	
None	

1. SITUATION

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

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

An Executive Summary is included on page 1 of our report.

Key points to note:

- **2023/24 progress:** Progress is being made on our 23/24 audits; three of the 18 planned reports have been issued in draft and one in final, three audits are in progress and four are at the planning stage.

- **2024/25 Planning:** 2024/25 planning is due to commence shortly, final approval of the 2024/25 Annual Plan is scheduled for the March 2023 Audit Committee. We attended the September 2023 EMB Shape meeting to set out the timeline and approach to achieve this with Trust management. We will attend the November 2023 EMB Shape meetings for further discussions around areas for inclusion in the plan.

4. SUMMARY OF MATTERS FOR CONSIDERATION

2023/24 Integrated Audit & Assurance Plan

The audit provision and associated fee for 2023/24 and future years were provided to management for inclusion within the Full Business Case.

Noting the delay in the achievement of financial close and the subsequent submission of the FBC, there is currently no approved Integrated Audit Plan (or funding provision) for further audit coverage during 2023/24.

nVCC Enabling Works (EW) report – update to 2022/23 report

Commencement of fieldwork to revisit this audit/report has been delayed due to Trust staff availability/sickness. We are currently awaiting confirmation of a revised audit commencement date from Trust management.

It was intended that an additional review would be delivered prior to financial close to ensure all associated (Enabling Works) delivery risks were addressed. The timing and content of this review will be reassessed during the fieldwork of the current exercise.

Timeliness of management responses

We attended the September 2023 EMB Shape meeting to:

- present an analysis of management response timeliness;
- highlight action taken to improve this; and
- identify any further action required.

An action plan is in place which will be monitored alongside the related KPI through our progress reporting to EMB.

The goal is for the KPI performance to be GREEN (70%+ responses provided in a timely manner) by the end of 2023/24.

Current performance

At the time of writing:

- management responses on one of the three draft reports issued were 12 working days overdue; and
- we have been unable to arrange timely meetings with key individuals for a further two draft reports; therefore, management responses for these will not be provided within the target timeframe.

This has impacted on delivery of these reports to the October Audit Committee.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
NO For 2023/24 onward, individual Internal Audit reports will be linked to the strategic goals in the cover paper for each individual report, where applicable.	
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)	10 - Governance

For more information: STRATEGIC RISK DESCRIPTIONS	Internal Audit reports are linked to the TAF in the Annual Internal Audit Plan. For 2023/24 onward, 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 onward, 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
	Not required for Internal Audit progress update report

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	Individual Internal Audit reports may provide assurance over the Wellbeing Goals.
	If more than one wellbeing goal applies please list below: From 2023/24 onward, 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.

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.
	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 onward, 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?	N/a
All risks must be evidenced and consistent with those recorded in Datix	

Internal Audit Progress & KPI Update Report

Velindre University NHS Trust

28th September 2023

Contents

Executive Summary

Alert / Escalate

Timeliness of management response

- We attended the September 2023 EMB Shape meeting to:
  - present an analysis of management response timeliness;
  - highlight action taken to improve this; and
  - identify any further action required.
- An action plan is in place which will be monitored alongside the related KPI through our progress reporting to EMB.
- The goal is for the KPI performance to be GREEN (70%+ responses provided in a timely manner) by the end of 2023/24.

Current performance

At the time of writing:

- management responses on one of the three draft reports issued were 12 working days overdue; and
- we have been unable to arrange timely meetings with key individuals for a further two draft reports; therefore, management responses for these will not be provided within the target timeframe.

This has impacted on delivery of these reports to the October Audit Committee.

nVCC Integrated Audit & Assurance Plan

- The audit provision and associated fee for 2023/24 and future years was provided to management for inclusion within the Full Business Case (initially targeted for submission to Welsh Government in March 2023).
- Noting the delay in the achievement of financial close and the subsequent submission of the FBC, there is currently no approved Integrated Audit Plan (or funding provision) for further audit coverage during 2023/24.

Advise

Timely issue of draft reports

- KPI 3 is currently RAG rated RED at 25% due to annual leave commitments over the summer period.
- We do not anticipate this to continue in the medium to longer-term, therefore expect performance to improve as 2023/24 progresses.

Advise (continued)

Capital audit fieldwork

nVCC Enabling Works

- Commencement of fieldwork to revisit this audit/report has been delayed due to Trust staff availability/sickness. We are currently awaiting confirmation of a revised audit commencement date from Management.
- It was intended that an additional review would be delivered prior to financial close to ensure all associated (Enabling Works) delivery risks were addressed. The timing and content of this review will be reassessed during the fieldwork of the current exercise.

Integrated Radiotherapy Solution

- Audit commencement deferred to Q4 at Trust management request.

Assure

2023/24 Progress

Of the 18 planned reviews:

- one report has been issued as final;
- three reports have been issued in draft;
- three audits are in progress; and
- four audits are at the planning stage.

Inform

Planning for 2024/24

- 2024/25 planning due to commence shortly, final approval of the 2024/25 Annual Plan scheduled for the March 2023 Audit Committee.
- We attended the September 2023 EMB Shape meeting to set out the timeline and approach to achieve this with Trust management.

Other activities

- Regular meetings with the Director of Finance;
- Planning meetings with various Executive Directors;
- Attendance at the 18th September EMB Shape meeting; and
- Attendance at Trust Board and Committee meetings.

Audit Status

Final Reports by Assurance Rating

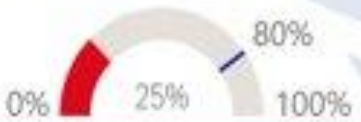
KPI Cumulative Performance

KPI1 - Timely delivery of Annual Plan & Report

Yes

KPI2 - Report delivery in line with plan

KPI3 - Timely issue of draft report



KPI4 - Timely management response

KPI5 - Timely finalisation of report

KPI6 - Delivery to planned Audit Committee

No

AUDIT COMMITTEE

Counter Fraud Progress Report

DATE OF MEETING	19/10/2023

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 read and review the report and any supplementary reports in order to gain a full understanding of the work carried out by the Counter Fraud team during the relevant period.

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 with whom regular liaison is sought. 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 ☐ • 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:	**Choose an item**

For more information: *https://www.gov.wales/socio-economic-duty-overview*	*[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.

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

30/06/2023 – 08/09/2023

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 30/06/2023 – 08/09/2023.

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– At this point in time there is no formal Corporate Induction taking place at Velindre UNHST. Liaison with Workforce and OD (WOD) and Information Governance undertaken to explore fresh avenues to achieve compliance with Fraud awareness.

Webinar Events – During this period a total of 6 webinar events have been held. (3x General fraud Awareness, 3 x Mandate Specific Fraud Awareness.)

No members of staff from Velindre UNHST have attended the webinars in this Quarter.

Intranet Site- during this Quarter the intranet site has received 121 visits.

Other/Ad Hoc/Trial promotional activity- A quarterly newsletter has been produced and disseminated and published on the intranet site. This can be found at the following link - Counter Fraud Newsletter - May 2023 (sharepoint.com) or via the QR Code provided above.

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 – 2

NHS Wales staff uptake – (*Figures not available at time of reporting. Verbal Update at meeting.*)

(since launch 04/23)

Prevention

Local Bulletins/Alerts – (0)

IBURN (intelligence bulletin) – (0)

FPN – (Fraud prevention notice) – (2)

1. FPN issued by NHS Counter Fraud Authority (NHSCFA) relating to working elsewhere during contracted hours. Dissemination to relevant stakeholders. Fraud risk assessment carried out and shared (copy provided with closed report).
2. FPN issued by NHS CFA as a reminder of the threat of Mandate fraud. Disseminated accordingly.

LPE (Local proactive exercise) – (1)

1. LPE carried out as a result of intelligence in relation to NHS Wales being targeted by fraudsters registering rogue companies at NHS addresses. Enquiries carried out with the organisation and Companies House. No issues discovered for VUNHST. Recorded appropriately on CLUE.

Fraud Risk

A further 3 fraud risk assessments conducted. Disseminated to nominated stakeholders and executive leads for review, action, and consideration for recording on local risk registers (Datix), as per the VUNHST Risk Management Policy.

The areas that the risk assessments have been submitted:

1. Working elsewhere during contracted hours – agile and remote working
2. Dishonest retention of salary overpayments
3. Medicine Storage- Pharmacy

Copies submitted in closed meeting report along with the 'Fraud Risk Profile' that provides status updates.

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	6
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

A total of two new referrals have been received-

1. Request for local investigation to assist another LCFS team. No offences in relation to VUNHST- assistance provided and matter closed

2. Bursary claims – promoted to Investigation.

One new investigation opened-

1. Relates to Bursary claim above. (See private report for further detail)

One investigation closed-

1. Procurement fraud – (See private report for further detail)

4. Other

NA

5. Appendices

NA

AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING	19/10/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ann Marie Stockdale, Head of Outpatient, Medical Records and Private Patient Services and David Osborne, Head of Finance Business Partnering
PRESENTED BY	David Osborne, Head of Finance Business Partnering
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 A review of the Velindre Cancer Centre (VCC) Private Patient Service debt management process and position was completed as part of an Internal Audit of the Trust's Core Financial Systems.

1.2 Committee raised some questions relating to the spike in the aged debt position and it was agreed that regular position up-dates would be provided.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Team have completed submission of invoices up to May 2023 period. Work on the remaining invoicing to Sept 2023 is underway and will be completed by November 2023, ensuring the 6 month turnaround time for invoicing with insurers is met.

2.2 The billing delays were due to resourcing issues within the team due to maternity and turnover within a small function, for example medical secretary and admin support has been mostly vacant since Nov 2022. Recruitment has now concluded for replacement of the Private Patient Medical Secretary and wider administrative support, and the Team is now operating at full capacity. This is reflected in the spike in recent invoiced income, combined with the further income generation through Liaison supported activities.

2.3 An external company (Liaison) had been appointment through the procurement route to support delivery of key objectives, including debt recovery. Liaison have been on site and working closely with the Private Patient Team, including supporting the billing process, enhancing governance and identifying opportunities for further income generation based on the existing service offer. Progress against objectives are reported at the Private Patient Improvement Group, Chaired by Nicola Williams, Executive Director of Nursing.

2.4 Direct outputs and improvements resultant from working in partnership with Liaison include:

	Retrospective additional revenue to Jun 2023	Monthly additional income from Jun 2023
Commercial		
• Full Reconciliation of Sciensus pathology service	£225,000	£12,500
• Allied Health Professional Services billed to insurance companies	£6,000	£1,000
• Four months billing (Oct-Jan) average additional income from increased data capture - pro rata to June (conservative estimate of 50% of current increase)	£247,845	£30,981
• Private pathology charges not previously captured - billed from Feb 23	£8,100	£2,250

Operational

- Six months of activity audited and validated (Jun-Dec 2022) - see billing revenue above for financial value
- Private patient database audited and updated to provide single "version of Truth" for new billing process
- Subscription to weekly BNF publishing for up to date drugs costs (previously 2016 reviewed manually each month)
- New billing process identified that uses internal BI resources without 3rd Party costs - requirements with Business Intelligence to make systematic operationally
- Review of staffing structure and recommendations for scrutiny, which have been endorsed and in process of being recruited to
- Private patient policy written
- Practising Privileges policy written
- Medical Advisory Committee clinical governance recommendations provided and Terms of Reference written
- Reviewed existing KPIs and introduced some industry standards
- CT and MRI review to enable joining of BUPA network contracts
- Revenue reconciliation - reversal of duplicate postings

2.5 The Private Patient Team in conjunction with Liaison have successfully realised the new income streams highlighted above, however, the issue of aged debt is ongoing to transact the identified corrections. The support provided via Liaison has significantly improved the future income streams and sound governance for the Private Patients Service, the identified corrections equate to £697k of the historic debt issues..

2.6 **It has been identified that a £697k proportion of aged debt greater than 180 days of £768k (90% of total debt greater than 180 days as at Sept 2023) has been received by the Trust but has not been applied to the Private Patient budget, this issue artificially inflates the issue of aged debt**. Going forward, a cross reference of the Unapplied and Unallocated Reports will be completed on a monthly basis to identify this income and prevent reoccurence. This action had been delayed due to staff limitations both within the Private Patients Team and wider Finance Function, though reviews of the current processes resulted in a corrective actions being undertaken in March period to remove duplication of invoicing identified. It is anticipated that transacting the identified corrections may take a number of weeks, due to the complexity of mapping individual patient debts and raising of credit/debit charges.

2.7 As an audit action, financial key performance indicators have been developed for consideration and agreement. These are as follows:-

Key Performance Indicators (Targets to be agreed)	31/05/2023	30/06/2023	30/07/2023	30/08/2023	30/09/2023
% Debts Payable by Insurance Companies	96.4%	95.8%	93.5%	94.7%	95.3%
% Debts Not Payable by Insurance Companies	3.6%	4.2%	6.5%	5.3%	4.7%
% Debts aged 30 days or less	25.4%	0.6%	0.0%	31.5%	21.5%
% Debts aged 31-180 days	28.0%	44.5%	30.3%	6.9%	28.2%
% Debts aged 181-365 days	21.9%	27.1%	39.1%	31.2%	22.9%
% Debts aged 1 year +	24.6%	27.8%	30.6%	30.5%	27.4%

Following feedback from the Audit Committee, an additional indicator has been added. The indicator calculation is derived from the total private patient value divided by the amount of income raised in the last twelve months (rolling year) times 365 days. The position is as follows:

Key Performance Indicator	31/05/2023	30/06/2023	30/07/2023	30/08/2023	30/09/2023

Days Sales Outstanding	137	135	130	136	146

Key Performance Indicators (Targets to be agreed)	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Debts recovered in month compared with total debt end of month	0.5%	0.6%	9.5%	10.6%	6.8%

2.8 The full report (Appendix 1) provides the breakdown of debt profile by age, value and customer category. The trend of the last 6 months illustrates that approximately 95% of private patient income will be derived from insurance companies.

2.9 The total days of sales outstanding has increased due to the aforementioned staffing issues which has now been addressed through recruitment. This is also the causation for fluctuating short term debt (0-90 days) variance between periods. The high volume of raising new debt is reflected in the total amount of debt, within the recent categories.

2.10 The present percentage of debts less than 180 days is 50%, which when compared to average of Apr-Sep 2021 (Audited Period of Debts as Reference Point of Base for Improvement) of 45%, reflecting an improvement in performance of aged debt, due to the aforementioned onboarding of staffing and additional income streams raised. Whilst the aged debt issue is not presently reflective of the identified correction of £697k, the future income streams supported by Liaison and the enhanced governance and processing procedures provides a positive direction moving forward.

Profile of Private Patient Debts As At Each Period End for the Financial Year to Date 30th September 2021							
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Average
Total Aged Debt	£294,641	£453,718	£349,481	£372,708	£449,410	£473,189	£398,858
Debt Due Less Than 180 Days - Value	£51,235	£221,779	£121,817	£189,746	£254,949	£290,437	£188,327
Debt Due Less Than 180 Days - Proportion	17%	49%	35%	51%	57%	61%	45%

3.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Prompt and efficient recovery of debts is important to the Trust to aid cash flow and reduce the amount of irrecoverable debts.

4.0 RECOMMENDATION

4.1 The Committee is asked to REVIEW and APPROVE the financial key performance indicators.

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

Appendix 1 – Aged Debt Report Sept 2023

Spreadsheet attached.

PP Appendix 1 Sept 2023.xlsx

***Totals of Debt Categories Per Aged Debt Report** (input values in grey shaded cells only)*

Movement between Months (brackets indicate increase in debts)

Key Performance Indicators (Targets to be agreed)	##########	##########	##########	##########	##########	##########	##########	##########	##########	##########	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
% Debts Payable by Insurance Companies	95.1%	95.4%	96.0%	95.1%	95.6%	94.7%	94.3%	96.8%	93.4%	97.4%	96.6%	96.9%	97.1%	97.0%	95.7%	95.7%	96.4%	95.8%	93.5%	94.7%	95.3%
% Debts Not Payable by Insurance Companies	4.9%	4.6%	4.0%	4.9%	4.4%	5.3%	5.7%	3.1%	6.6%	2.6%	3.4%	3.1%	2.9%	3.0%	4.3%	4.3%	3.6%	4.2%	6.5%	5.3%	4.7%
% Debts aged 30 days or less	33.6%	17.0%	44.5%	0.2%	28.0%	12.3%	0.0%	47.0%	43.4%	12.5%	25.2%	25.0%	35.1%	13.5%	0.3%	0.0%	25.4%	0.6%	0.0%	31.5%	21.5%
% Debts aged 31-180 days	33.4%	49.7%	25.6%	52.3%	24.2%	33.1%	38.2%	17.1%	20.1%	51.1%	36.3%	38.8%	31.1%	49.8%	52.8%	49.3%	28.0%	44.5%	30.3%	6.9%	28.2%
% Debts aged 181-365 days	10.8%	13.0%	15.3%	27.0%	23.3%	27.3%	28.2%	16.5%	13.8%	12.0%	11.1%	10.7%	10.2%	13.1%	15.1%	18.2%	21.9%	27.1%	39.1%	31.2%	22.9%
% Debts aged 1 year +	22.2%	20.2%	14.7%	20.5%	24.5%	27.3%	33.6%	19.3%	22.7%	24.4%	27.2%	25.6%	23.5%	23.6%	31.8%	32.5%	24.6%	27.8%	30.6%	30.5%	27.4%
Days sales outstanding			126	83	91	78	79	122	52	128	117	116	132	134	107	115	137	135	130	136	146

Key Performance Indicators (Targ	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**30/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Debts recovered in month compar	7.9%	17.2%	63.3%	20.1%	25.0%	6.8%	0.1%	180.5%	-46.6%	34.9%	20.6%	15.7%	15.3%	29.3%	0.5%	0.5%	0.6%	9.5%	10.6%	6.8%

All debts	##########	##########	##########	##########	##########	##########	##########	##########	##########	##########	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Within maturity (0-30 days)	194,349	108,522	389,682	932	163,241	63,800	0	429,597	167,379	118,239	217,211	225,299	392,686	148,938	2,404	0	286,568	6,826	0	409,468	327,771
31-60 days	44,949	151,954	89,972	141,409	328	89,335	48,263	0	58,168	160,372	33,900	147,878	0	257,513	142,233	0	0	283,819	22,964	0	335,523
61-90 days	40,168	43,327	46,511	61,064	36,376	328	80,645	48,263	0	241,246	131,489	27,380	201,858	98,580	84,974	142,233	0	0	234,879	22,964	600
91-180 days	107,874	121,265	87,415	78,248	104,269	81,331	55,854	107,641	19,360	79,954	146,922	174,079	146,254	191,621	222,926	275,546	316,377	217,566	53,871	66,573	93,228
181-365 days	62,635	82,974	133,660	145,049	135,991	141,214	136,686	150,957	53,004	113,282	95,449	96,078	114,246	143,511	128,431	154,239	247,447	305,621	402,817	406,243	349,653
1 year +	128,476	128,824	128,579	110,099	142,493	141,201	162,844	176,682	87,363	229,765	234,267	230,611	263,076	259,130	270,969	275,277	277,983	314,077	315,505	396,393	418,244
Total	**578,452**	**636,867**	**875,819**	**536,803**	**582,698**	**517,211**	**484,293**	**913,140**	**385,275**	**942,858**	**861,497**	**901,325**	**1,118,120**	**1,099,295**	**851,937**	**847,295**	**1,128,375**	**1,127,909**	**1,030,036**	**1,301,641**	**1,525,019**

All debts	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**31/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Within maturity (0-30 days)	85,827	(281,159)	388,750	(162,309)	99,441	63,800	(429,597)	262,218	49,140	(98,972)	(8,088)	(167,387)	243,748	146,534	2,404	(286,568)	279,742	6,826	(409,468)	81,697
31-60 days	(107,005)	61,982	(51,437)	141,081	(89,007)	41,071	48,263	(58,168)	(102,204)	126,472	(113,978)	147,878	(257,513)	115,280	142,233	0	(283,819)	260,855	22,964	(335,523)
61-90 days	(3,159)	(3,184)	(14,554)	24,688	36,048	(80,317)	32,382	48,263	(241,246)	109,757	104,109	(174,478)	103,278	13,606	(57,259)	142,233	0	(234,879)	211,915	22,364
91-180 days	(13,390)	33,850	9,167	(26,020)	22,938	25,477	(51,787)	88,281	(60,594)	(66,968)	(27,157)	27,825	(45,367)	(31,305)	(52,620)	(40,831)	98,811	163,695	(12,702)	(26,655)
181-365 days	(20,339)	(50,686)	(11,389)	9,058	(5,223)	4,528	(14,270)	97,953	(60,278)	17,833	(629)	(18,168)	(29,265)	15,080	(25,808)	(93,208)	(58,174)	(97,196)	(3,426)	56,590
1 year +	(348)	245	18,480	(32,394)	1,290	(21,642)	(13,838)	89,319	(142,402)	(4,502)	3,656	(32,465)	3,946	(11,839)	(4,308)	(2,706)	(36,094)	(1,428)	(80,888)	(21,851)
Total	**(58,415)**	**(238,952)**	**339,017**	**(45,896)**	**65,488**	**32,918**	**(428,847)**	**527,866**	**(557,584)**	**83,620**	**(42,087)**	**(216,795)**	**18,827**	**247,356**	**4,642**	**(281,080)**	**466**	**97,873**	**(271,605)**	**(223,378)**

Insured	##########	##########	##########	##########	##########	##########	##########	##########	##########	##########	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Within maturity (0-30 days)	191,500	102,991	380,725	0	163,241	63,800	0	427,667	166,301	118,239	213,176	224,389	387,311	142,008	2,404	0	281,645	425	0	407,622	318,619
31-60 days	43,477	151,397	85,044	141,409	0	89,335	48,263	0	58,168	159,294	33,900	143,915	0	257,586	134,484	0	0	278,896	425	0	334,186
61-90 days	40,018	42,025	46,511	57,174	36,376	0	80,645	48,263	0	241,246	130,411	27,380	197,642	98,580	83,082	134,484	0	0	229,956	425	600
91-180 days	100,720	116,223	82,333	77,550	99,891	76,538	50,733	106,410	19,359	79,954	146,922	173,001	145,176	187,613	218,819	269,547	306,848	208,614	46,568	62,206	71,064
181-365 days	62,479	82,648	133,334	139,831	130,889	135,664	131,137	141,686	45,403	108,338	92,573	92,045	114,103	143,368	127,798	153,607	243,285	300,882	393,173	388,850	333,787
1 year +	111,925	112,273	112,895	94,390	126,653	124,508	146,149	159,817	70,644	211,157	215,484	212,430	241,005	237,059	248,755	253,062	255,768	291,862	293,291	374,179	394,952
Total	550,120	607,558	840,842	510,355	557,051	489,845	**456,927**	**883,844**	**359,875**	**918,230**	**832,468**	**873,160**	**1,085,237**	**1,066,216**	**815,342**	**810,700**	**1,087,546**	**1,080,679**	**963,413**	**1,233,282**	**1,453,208**

Insured	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**31/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Within maturity (0-30 days)	88,509	(277,733)	380,725	(163,241)	99,441	63,800	(427,667)	261,366	48,062	(94,937)	(11,213)	(162,922)	245,303	139,604	2,404	(281,645)	281,220	425	(407,622)	89,003
31-60 days	(107,920)	66,353	(56,365)	141,409	(89,335)	41,071	48,263	(58,168)	(101,126)	125,394	(110,015)	143,915	(257,586)	123,102	134,484	0	(278,896)	278,471	425	(334,186)
61-90 days	(2,007)	(4,486)	(10,664)	20,798	36,376	(80,645)	32,382	48,263	(241,246)	110,835	103,031	(170,262)	99,062	15,498	(51,402)	134,484	0	(229,956)	229,531	(175)
91-180 days	(15,502)	33,890	4,783	(22,340)	23,353	25,805	(55,677)	87,051	(60,595)	(66,968)	(26,079)	27,825	(42,437)	(31,206)	(50,728)	(37,301)	98,234	162,046	(15,638)	(8,858)
181-365 days	(20,169)	(50,686)	(6,497)	8,942	(4,775)	4,528	(10,550)	96,283	(62,935)	15,765	528	(21,058)	(29,265)	15,570	(25,809)	(89,678)	(57,597)	(92,291)	4,323	55,063
1 year +	(348)	(622)	18,505	(32,263)	2,145	(21,642)	(13,668)	89,173	(140,513)	(4,327)	3,054	(28,575)	3,946	(11,696)	(4,307)	(2,706)	(36,094)	(1,429)	(80,888)	(20,773)
Total	**(57,437)**	**(233,285)**	**330,487**	**(46,695)**	**67,206**	**32,918**	**(426,917)**	**523,969**	**(558,353)**	**85,762**	**(40,694)**	**(212,077)**	**19,023**	**250,872**	**4,642**	**(276,846)**	**6,867**	**117,266**	**(269,869)**	**(219,926)**

Not Insured (Self payers, Top Ups and Overseas debts, further analysed below)																				
Within maturity (0-30 days)	2,849	5,531	8,957	932	0	0	0	1,193	0	0	4035	910	5374	6929	0	0	4923	6401	0	1,846	9,152
31-60 days	1,472	557	4,928	0	328	0	0	0	1,078	1,078	0	3,963	0	-73	7,749	0	0	4,923	22,539	0	1,337
61-90 days	150	1,302	0	3,890	0	328	0	0	0	0	1,078	0	4,216	0	1,892	7,749	0	0	4,923	22,539	0
91-180 days	7,154	5,042	5,082	698	4,378	4,793	5,121	1,231	0	0	0	1,078	1,078	4,008	4,107	5,999	9,529	8,952	7,303	4,367	22,164
181-365 days	156	326	326	5,218	5,102	5,550	5,550	9,270	7,601	4,943	5,131	4,033	143	143	633	632	4,162	4,739	9,644	17,393	15,866
1 year +	16,551	16,551	15,684	15,709	15,840	16,695	16,695	16,865	16,718	18,607	18,782	18,180	22,071	22,071	22,214	22,214	22,214	22,214	22,214	22,214	23,292
Total	28,332	29,309	34,977	26,447	25,648	27,366	**27,366**	**28,559**	**25,397**	**24,629**	**29,028**	**28,164**	**32,882**	**33,079**	**36,595**	**36,594**	**40,828**	**47,229**	**66,623**	**68,359**	**71,811**

Not Insured (Self payers, Top Ups and Overseas debts, further analysed below)	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**31/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Within maturity (0-30 days)	(2,682)	(3,426)	8,025	932	0	0	(1,193)	1,193	0	(4,035)	3,125	(4,464)	(1,555)	6,929	0	(4,923)	(1,478)	6,401	(1,846)	(7,306)
31-60 days	915	(4,371)	4,928	(328)	328	0	0	(1,078)	0	1,078	(3,963)	3,963	73	(7,822)	7,749	0	(4,923)	(17,616)	22,539	(1,337)
61-90 days	(1,152)	1,302	(3,890)	3,890	(328)	328	0	0	0	(1,078)	1,078	4,216	4,216	(1,892)	(5,857)	7,749	0	(4,923)	(17,616)	22,539
91-180 days	2,112	(40)	4,384	(3,680)	(415)	(328)	3,890	1,231	0	0	(1,078)	0	(2,930)	(99)	(1,892)	(3,530)	577	1,649	2,936	(17,797)
181-365 days	(170)	0	(4,892)	116	(448)	0	(3,720)	1,669	2,658	(188)	1,098	3,890	0	(490)	1	(3,530)	(577)	(4,905)	(7,749)	1,527
1 year +	0	867	(25)	(131)	(855)	0	(170)	147	(1,889)	(175)	602	(3,891)	0	(143)	0	0	0	0	0	(1,078)
Total	**(977)**	**(5,668)**	**8,530**	**799**	**(1,718)**	**0**	**(1,193)**	**3,162**	**769**	**(4,398)**	**862**	**(4,718)**	**(196)**	**(3,517)**	**1**	**(4,234)**	**(6,401)**	**(19,394)**	**(1,736)**	**(3,452)**

Self payer																				
Within maturity (0-30 days)	0	0	809	0	0	0	0	1,930	446	0	4,035	910	1,805	6,929	0	0	860	0	1,337	6,526
31-60 days	380	0	0	0	0	0	0	0	0	446	0	3,963	0	(73)	7,749	0	0	860	0	1,337
61-90 days	150	210	0	0	0	0	0	0	446	0	4,216	0	1,805	7,749	0	0	860	0	0	0
91-180 days	260	410	450	360	150	903	903	903	0	0	446	446	3,375	4,107	5,912	9,442	8,865	7,303	304	750
181-365 days	170	170	170	430	470	580	580	410	1,203	1,053	903	141	143	143	0	3,530	4,107	5,843	13,598	12,703
1 year +	1,098	1,098	231	256	231	1,086	1,086	1,256	1,110	1,491	1,666	726	726	726	869	869	869	869	869	1,315
Total	1,888	1,888	1,660	1,046	851	2,569	**2,569**	**4,499**	**2,759**	**2,990**	**7,051**	**6,186**	**7,336**	**11,102**	**14,530**	**14,530**	**14,701**	**14,701**	**14,881**	**16,108**	**22,631**

Self payer	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**31/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Within maturity (0-30 days)	0	(809)	809	0	0	0	(1,930)	1,484	446	(4,035)	3,125	(895)	(5,124)	6,929	0	(860)	860	0	(1,337)	(5,189)
31-60 days	380	0	0	0	0	0	0	0	(446)	446	(3,963)	3,963	73	(7,822)	7,749	0	(860)	860	0	(1,337)
61-90 days	(60)	210	0	0	0	0	0	0	0	(446)	446	(4,216)	4,216	(1,805)	(5,944)	7,749	0	(860)	860	0
91-180 days	(150)	(40)	90	210	(753)	0	0	903	0	0	(446)	0	(2,929)	(732)	(1,805)	(3,530)	577	1,562	6,999	(446)
181-365 days	(170)	0	(260)	(40)	(110)	0	170	(793)	150	150	762	(2)	0	143	0	(3,530)	(577)	(1,742)	(7,749)	895
1 year +	0	867	(25)	25	(855)	0	(170)	146	(381)	(175)	940	0	0	(143)	0	0	0	0	0	(446)
Total	**0**	**228**	**614**	**195**	**(1,718)**	**0**	**(1,930)**	**1,740**	**(231)**	**(4,060)**	**864**	**(1,150)**	**(3,764)**	**(3,430)**	**0**	**(171)**	**0**	**(180)**	**(1,227)**	**(6,523)**

Top Up																				
Within maturity (0-30 days)	0	5,531	8,148	932	0	0	0	0	632	0	0	0	3,569	0	0	0	4,063	6,401	0	0	2,626
31-60 days	338	0	4,928	0	328	0	0	0	0	632	0	0	0	0	0	0	0	4,063	6,099	0	0
61-90 days	0	338	0	3,890	0	328	0	0	0	0	632	0	0	87	0	0	0	4,063	6,099	0	6,099
91-180 days	6,894	4,632	4,632	338	4,228	3,890	4,218	328	0	0	0	632	632	632	0	87	87	87	4,063	4,974	
181-365 days	156	156	156	4,788	4,632	4,970	4,970	8,860	6,398	3,890	4,228	3,890	0	0	633	632	632	632	719	719	87
1 year +	15,453	15,453	15,453	15,453	15,609	15,609	15,609	15,609	15,609	17,116	17,116	17,454	21,344	21,344	21,345	21,345	21,345	21,345	21,345	21,977	
Total	22,841	26,110	33,317	25,401	24,797	24,797	**24,797**	**24,797**	**22,639**	**21,639**	**21,977**	**21,976**	**25,545**	**21,977**	**22,065**	**22,064**	**26,127**	**32,528**	**32,226**	**32,226**	**29,664**

Top Up	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**31/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Within maturity (0-30 days)	(5,531)	(2,617)	7,216	932	0	0	0	(632)	632	0	0	(3,569)	3,569	0	0	(4,063)	(2,338)	6,401	0	(2,626)
31-60 days	338	(4,928)	4,928	(328)	328	0	0	0	(632)	632	0	0	0	0	0	0	(4,063)	(2,036)	6,099	0
61-90 days	(338)	338	(3,890)	3,890	(328)	328	0	0	0	(632)	632	0	0	(87)	87	0	0	(4,063)	(2,036)	6,099
91-180 days	2,262	0	4,294	(3,890)	338	(328)	3,890	328	0	0	(632)	0	0	632	(87)	0	0	4,063	(911)	
181-365 days	0	0	(4,632)	156	(338)	0	(3,890)	2,462	2,508	(338)	338	3,890	(0)	(633)	1	0	0	(87)	0	632
1 year +	0	0	0	(156)	0	0	0	(0)	(1,507)	0	(338)	(3,890)	0	11	0	0	0	0	0	(632)
Total	**(3,269)**	**(7,207)**	**7,916**	**604**	**(0)**	**0**	**(0)**	**2,158**	**1,001**	**(338)**	**0**	**(3,569)**	**3,569**	**(89)**	**1**	**(4,063)**	**(6,401)**	**302**	**0**	**2,562**

Overseas																				
Within maturity (0-30 days)	2,849	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	509	0	
31-60 days	754	557	0	0	0	0	0	0	0	0	0	0	0	0	0	16,440	0	0		
61-90 days	0	754	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,440	0		
91-180 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,440		
181-365 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3,076	3,076	3,076		
1 year +	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total	3,603	1,311	0	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**19,516**	**20,025**	**19,516**		

Overseas	**28/02/2022**	**31/03/2022**	**30/04/2022**	**31/05/2022**	**30/06/2022**	**31/07/2022**	**31/08/2022**	**31/09/2022**	**31/10/2022**	**30/11/2022**	**31/12/2022**	**31/01/2023**	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**	**30/07/2023**	**30/08/2023**	**30/09/2023**
Within maturity (0-30 days)	2,849	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
31-60 days	197	557	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
61-90 days	(754)	754	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
91-180 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
181-365 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 year +	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2,292**	**1,311**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

AUDIT COMMITTEE

Losses & Special Payments Report 2023/2024

DATE OF MEETING	19/10/2023

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 01/04/2023 – 31/08/2023.

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 Write off of the debts summarised below 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**

2.2 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.

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

2.4 The Trust has also agreed the following items under the Losses and Compensation procedure, to the value of £6,600:

2.4.1 Reimbursement for the cost of replacing glasses;
2.4.2 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 1/4/2023 – 31/08/2023: • Debts totaling £12,910 have been written off; • Two payments under the Losses and Compensation Procedure have been agreed, for a total of £6,600.

4. RECOMMENDATION

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

AUDIT COMMITTEE

REVISIONS TO THE MODEL STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS FOR NHS TRUSTS; AND STANDING FINANCIAL INSTRUCTIONS

DATE OF MEETING	19/10/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The purpose of this report is to advise the Audit Committee of the: • Further revisions to the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales have been undertaken by Welsh Government. The changes are: a) Linked to the establishment of **Llais (Citizen Voice Body)**.

	b) Linked to **Notifying and equipping Board members**, the number of calendar days for Board members to be sent an agenda and a complete set of supporting papers **has reduced to 7 calendar days** before a formal Board meeting. • The review of the Standing Financial Instructions undertaken by Welsh Government, which are Schedule 2.1 of the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales. The changes are: a) Updated hyperlinks for the Governance e-Manual which is now on the NHS Wales Shared Services Partnership external website. b) Updated contact information for Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. c) Update to 6.2 in relation to the Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement. d) Updated Schedule 1 – Revised General Consent to Enter Individual Contracts.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to **ENDORSE** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Standing Financial Instructions for submission to the Trust Board for approval. Following Trust Board APPROVAL, these changes will be enacted with immediate effect and published on the Trust website.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run	02/10.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Executive Management Board **ENDORSED** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Standing Financial Instructions for submission to the Audit Committee for endorsement to submit to the Trust Board for approval.	

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

APPENDICES	
Appendix 1	Revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Standing Financial Instructions

1. SITUATION

Velindre University National Health Service Trust is a statutory body that came into existence on 1st December 1993 under the Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838), as amended, "the Establishment Order".

Velindre University NHS Trust has a duty under Regulation 19(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990 to make Standing Orders for the regulation of their proceedings and business. It is important to note that the Trust is able to vary or suspend its own Standing Orders, providing that it is able to satisfy that it complies with the relevant regulations.

2. BACKGROUND

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales. All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

3. ASSESSMENT

Welsh Government has undertaken further revisions to the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales, since they were presented to the Trust Board in July 2023.

The changes are:

a) Linked to the establishment of **Llais (Citizen Voice Body)**;
b) Linked to Notifying and equipping Board members, the number of calendar days for Board members to be sent an agenda and a complete set of supporting papers has reduced to **7** calendar days before a formal Board meeting.

Welsh Government has undertaken a review of the Standing Financial Instructions, which are Schedule 2.1 of the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales.

The changes are:

c) Updated hyperlinks for the Governance e-Manual which is now on the NHS Wales Shared Services Partnership external website.
d) Updated contact information for Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts.
e) Update to 6.2 in relation to the Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Audit Committee is asked to **ENDORSE** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Standing Financial Instructions for submission to the Trust Board for approval.

Following Trust Board APPROVAL, these changes will be enacted with immediate effect and published on the Trust website.

5. 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*	10 - Governance

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). Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the activity outlined in this report.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
	There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report.*
	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*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is essential that the Trust complies with its standing orders.

6. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

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	

Model Standing Orders

Reservation and Delegation of Powers

Velindre University NHS Trust

Foreword

These Model Standing Orders are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. National Health Service Trusts ("NHS Trusts") in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs Trusts must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

They are designed to translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024) as amended] into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of directors; a Scheme of decisions to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework GC03 Standards of Behaviour Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Trust's Director of Corporate Governance will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the Trust.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

Contents

Section A – Introduction

Statutory framework

i) Velindre University National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838),** as amended, "the Establishment Order".]

ii) The principal place of business of the Trust is –
Velindre University NHS Trust Headquarters, 2 Charnwood Court, Parc Nantgarw, Cardiff, CF15 7QZ

iii) All business shall be conducted in the name of Velindre University National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee.

iv) NHS Trusts are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

v) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024)**, as amended ("the Membership Regulations") set out the membership and procedural arrangements of the Trust.

vi) Sections 18 and 19 of and Schedule 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give directions about how they exercise those functions. NHS Trusts must act in accordance with those directions. The NHS Trust's main statutory functions are set out in their Establishment Order but additional functions may also be contained in other legislation, such as the NHS (Wales) Act 2006.

vii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

NHS Trusts will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

viii) The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

ix) In exercising their powers NHS Trusts must be clear about the statutory basis for exercising such powers.

x) In addition to directions the Welsh Ministers may from time to time issue guidance which NHS Trusts must take into account when exercising any function.

xi) NHS Trusts work closely with the seven Local Health Boards (LHBs) in Wales. The chief executive of the Trust is an associate member of the following joint-committees of the LHBs:

- The Welsh Health Specialised Services Committee, and
- The Emergency Ambulance Service Committee.

xii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)** which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

xiii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8 (W.08))** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8 (W.8))** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee ("EASC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution and membership of the EASC including its procedures and administrative arrangements.

xiv) **The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012) (as amended) require the Trust to establish a Shared Services Committee and prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

xv) **The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014.**

xvi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes

NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trust and, for the purposes of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xvii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xviii) The Welsh Language (Wales) Measure 2011 makes provision with regard to the development of standards of conduct relating to the Welsh Language. These standards replace the requirement for a Welsh Language Scheme previously provided for Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of NHS Trusts. The Trust will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xix) Paragraph 18 of Schedule 3 to the NHS (Wales) Act 2006 provides for NHS Trusts to enter into arrangements for the carrying out, on such terms as considered appropriate, of any of its functions jointly with any Strategic Health Authority, Local Health Board or other NHS Trust, or any other body or individual.

xx) NHS Trusts are also bound by any other statutes and legal provisions which govern the way they do business. The powers of NHS Trusts established under statute shall be exercised by NHS Trusts meeting in public session, except as otherwise provided by these SOs.

NHS framework

xxi) In addition to the statutory requirements set out above, NHS Trusts must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xxii) Adoption of the principles will better equip NHS Trusts to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xxiii) The overarching NHS governance and accountability framework incorporates these SOs; the Scheme of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

xxiv) The Welsh Ministers, reflecting their constitutional obligations, and legal duties under the **Well-being of Future Generations (Wales) Act 2015 (2015/2)**, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

The Trust is considered a public body under the Act.

xxv) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of NHS Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

NHS Trust framework

xxvi) Schedule 2 provides details of the key documents that, together with these SOs, make up the NHS Trust's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxvii) NHS Trusts will from time to time agree and approve policy statements which apply to the Trust's Board of directors and/or all or specific groups of staff employed by Velindre National Health Service Trust and others. The decisions to approve these policies will be recorded and, where appropriate, will also be considered to be an integral part of the Trust's SOs and SFIs. *Details of the Trust's key policy statements are also included in Schedule 2.*

xxviii) NHS Trusts shall ensure that an official is designated to undertake the role of the Director of Corporate Governance (the role of which is set out in paragraph xxxvi) below).

xxix) For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SO 1.1.2 refers.

Applying Standing Orders

xxx) The SOs of NHS Trusts (together with SFIs and the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the Trust, including any sub-Committees and Advisory Groups. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.*

xxxi) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non-compliance to the Director of Corporate Governance as soon as they are aware of any circumstance that has not previously been reported.

xxxii) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxxiii) Although these SOs are subject to regular, annual review by the NHS Trust, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Director of Corporate Governance shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 19] of the Membership Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;

- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and

- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxiv) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the Trust shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Director of Corporate Governance and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxxv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Director of Corporate Governance

xxxvi) The role of the Director of Corporate Governance is crucial to the ongoing development and maintenance of a strong governance framework within NHS Trusts, and is a key source of advice and support to the NHS Trust Chair and other Board members. Independent of the Board, the Director of Corporate Governance acts as the guardian of good governance within NHS Trusts. The Director of Corporate Governance is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of NHS Trust business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the NHS Trust compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

As advisor to the Board, the Director of Corporate Governance's role does not affect the specific responsibilities of Board members for governing the organisation. The Director of Corporate Governance is directly

accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

Further details on the role of the Director of Corporate Goverance within Velindre University NHS Trust, including details on how to contact them, is available from the Trust by contacting the Trust on 02920 196161 or visiting the Trust's public internet site.

Section B – Standing Orders

1. THE TRUST

1.0.1 The Trust's principal role is to:

(a) to own and manage Velindre Hospital, Velindre Road, Whitchurch, Cardiff CF4 7XL and associated hospitals and premises, and there to provide and manage hospital accommodation and services;

(b) to own and manage Welsh Blood Service Headquarters, Ely Valley Road, Talbot Green, Pontyclun CF72 9WB and associated premises, and there to provide and manage services relating to the collection, screening and processing of blood and its constituents and to the preparation and supply of blood, plasma and other blood products;

(c) services relating to prescribing and dispensing;

(d) to manage and provide Shared Services to the health service in Wales;

(e) to own or lease the premises associated with the provision of the services in paragraph (d), and

(f) to manage and administer the Wales Infected Blood Support Scheme in accordance with directions issued by the Welsh Ministers.

1.0.2 The Trust was established by, and its functions are contained in, the **Velindre National Health Service Trust (Establishment) Order 1993** (S.I. 1993/2838), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

1.0.3 To fulfil this role, the Trust will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Trust

1.1.1 The membership of the Trust shall comprise the Chair, Vice-Chair, 6 non-executive directors and 6 executive directors.]

1.1.2 For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively. The

Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights.

1.1.3 The Minister for Health and Social Services shall appoint the Chair and non-officer members of the Trust.

1.1.4 The Trust will appoint a Committee whose members will be the Chair and non-executive directors of the Trust whose function will be to appoint the Chief Executive as a director of the Trust.

1.1.5 The Trust will appoint a Committee whose members will be the chair, the non-executive directors and the Chief Executive whose function will be to appoint the executive directors other than the Chief Executive.

Executive Directors

1.1.6 A total of 6, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance, a medical or dental practitioner (to be known as the Medical Director), a registered nurse or registered midwife (to be known as the Nurse Director) and 2 others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

Non-executive directors [to be known as Independent Members]

1.1.7 A total of 6 (excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services, which will include:

- A person appointed from Cardiff University.

1.1.8 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Membership Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice-Chair
- Non-Executive Directors

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the Trust is shared between more than one person because of their being appointed jointly to a post:

(i) Either or both persons may attend and take part in Board meetings;
(ii) If both are present at a meeting they shall cast one vote if they agree;
(iii) In the case of disagreement no vote shall be cast; and
(iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term**.**]

1.3.2 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.3 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.4 The Trust will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the Trust, its Board and responsibilities of individual members

Role

1.4.1 The principal role of the Trust is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through

effective challenge and scrutiny of the Trust's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 NHS Trusts shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the Trust within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Director of Corporate Governance, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.9 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They are the

appointed Accountable Officer for the Trust and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.10 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the Trust, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

(i) Schedule of matters reserved to the Board;
(ii) Scheme of delegation to committees and others; and
(iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 The Trust retains full responsibility for any functions delegated to others to carry out on its behalf. Where Trusts and Local Health Boards have a joint duty the Trust remains fully responsible for its part, and shall agree the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other

Independent Members. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

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

2.2 Delegation of Board functions

2.2.1 The Trust shall delegate its Shared Services functions (that is, the provision and management of Shared Services to the health services in Wales) to the Shared Services Partnership Committee which they are required to establish and confer such functions on in accordance with the Shared Services Regulations.

Subject to Standing Order 2.2.2 the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2 (i), to Committees and others, setting any conditions and restrictions it considers necessary and in accordance with any directions or regulations given by the Welsh Ministers. These functions may be carried out:

(i) By a Committee, sub-Committee or officer of the Trust (or of another Trust); or
(ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
(iii) With one or more bodies including local authorities through a sub-Committee.]

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees or sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may

periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 NHS Trust Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term "Committee"

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- sub-Committee

unless otherwise stated.

3.2 Sub-Committees

3.2.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.3 Committees established by the Trust

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds *[as appropriate]*;

- Remuneration and Terms of Service; and
- Mental Health Act requirements *[as appropriate]*.

3.3.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity;
- Maximise cohesion and integration across all aspects of governance and assurance.

3.3.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board**,** its Committees and any Advisory Groups);
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.3.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

3.3.6 Executive Directors or other Trust officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated Trust officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.4 Other Committees

3.4.1 The Board may also establish other Committees to help the Trust in the conduct of its business.

3.5 Confidentiality

3.5.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.6 Reporting activity to the Board

3.6.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs, Trusts and Special Health Authorities setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The Trust may and where directed by the Welsh Ministers must, appoint Advisory Groups to the Trust to provide advice to the Board in the exercise of its functions.

5.0.2 *Details of the Trust's Advisory Groups, their membership and terms of reference are set out in Schedule 4.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Advisory Groups established by the Trust

5.1.1 The Trust has established the following Advisory Groups:

- Local Partnership Forum

5.2 Terms of reference and operating arrangements

5.2.1 The Board must formally approve terms of reference and operating arrangements in respect of any Advisory Group it has established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the Board, its Committees and Advisory Groups) as well as other relevant local and national groups;
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.2.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements for the Trust's Advisory Groups are set out in Schedule 4.

5.2.3 The Board may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.3 Support to Advisory Groups

5.3.1 The Trust's Director of Corporate Governance, on behalf of the Chair, will ensure that Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the Trust Board and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see 5.7 and Schedule 4);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.4 Confidentiality

5.4.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.5 Advice and feedback

5.5.1 The Trust may specifically request advice and feedback from the Advisory Group(s) on any aspect of its business and they may also offer advice and feedback even if not specifically requested by the Trust. The Group(s) may provide advice to the Board:

- In written advice;
- In any other form specified by the Board

5.6 Reporting activity

5.6.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.6.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.6.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.7 The Local Partnership Forum (LPF)

Role

5.7.1 The LPF's role is to provide a formal mechanism where the Trust, as employer, and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

5.7.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.8 Relationship with the Board and others

5.8.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.8.2 The Board may determine that designated Board members or Trust staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or Trust staff, subject to the agreement of the Trust Chair.

5.8.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

5.8.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.8.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 4 for detailed Terms of Reference and Operating Arrangements.

6. WORKING IN PARTNERSHIP

6.0.1 The Trust shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the Trust through:

- The Trust's own structures and operating arrangements, e.g., Advisory Groups; and

- The involvement (at very local and community wide levels) in partnerships and community groups – such as Public Service Boards – of Board members and Trust officers with delegated authority to represent the Trust and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 The Citizen Voice Body for Health and Social Care, Wales (known as Llais)

6.1.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales)**

Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on Trusts in relation to the engagement and involvement of Llais in its operations.

6.1.2 The 2020 Act places a statutory duty on the Trust to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.3 The 2020 Act also places a statutory duty on the Trust to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The Trust must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant)

The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's functions, the Board shall work constructively with the Board of Llais to ensure that regional offices of Llais are involved, as appropriate, in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, formally consulting and working jointly with Llais on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023 .

The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

6.1.5 The Board shall ensure Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.6 The Board may determine that a designated Llais representative (s) shall be invited to attend Board meetings.

6.1.7 The Board shall ensure arrangements are in place for regular meetings between Trust officers and representatives of Llais.

6.1.8 The Board's Chair shall put in place arrangements to meet with the Chair or Deputy Chair and/or representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The Trust's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The Trust, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested and required) and in electronic formats;
- Requesting that attendees notify the Trust of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the Trust's citizens and other stakeholders, including any views expressed formally to the Trust, e.g., through Llais.

7.2 Annual Plan of Board Business

7.2.1 The Director of Corporate Governance, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include

proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the Trust to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website.

Annual General Meeting (AGM)

7.2.5 The Trust must hold an AGM in public no later than the 31 July each year. [Note : this will be no later than 30 September in 2023 to take account of the timetable for audit and laying of the Accounts by Audit Wales.] At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the Trust's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the Trust are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Director of Corporate Governance, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the Trust. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Director of Corporate Governance, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 7 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Director of Corporate Governance, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must

consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the Trust's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The Trust shall encourage attendance at its formal Board meetings by the public and members of the press as well as Trust officers or representatives from organisations who have an interest in Trust business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> *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*

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Director of Corporate Governance, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Trust, (whether directly or through the activities of bodies such as Llais and the Trust's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the Trust will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so,

the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Director of Corporate Governance. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least one-third of all Board members, at least one of whom is an Executive Director and one is an Independent Members, must be present to allow any formal business to take place at a Board meeting.]

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Director of Corporate Governance will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter

shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e.., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the Trust's citizens and stakeholders. Such views will usually be presented to the Board through the Chair*(s)* of the Trust's Advisory Group*(s)* and the Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the Trust's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulations 2018, and the Trust's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members together with members of any Committee or Advisory Group established by or on behalf of the Board and Trust officials must respect the confidentiality of all matters considered by the Trust in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework GC03 Standards of Behaviour Policy or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the Trust that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Trust, including Board members, Trust officers and others, as appropriate. The framework adopted by the Board is the Trust's Standards of Behaviour Policy (GC03) and will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy and their statutory duties under the Membership Regulations. Board members must notify the Chair and Director of Corporate Governance of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Director of Corporate Governance will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Director of Corporate Governance. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Director of Corporate Governance will ensure that a Register of Interests is

established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Director of Corporate Governance, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Director of Corporate Governance will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Director of Corporate Governance must take reasonable steps to ensure that the citizens served by the Trust are made aware of, and have access to view the Trust's Register of Interests. This may include publication on the Trust's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the Trust's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Director of Corporate Governance, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the Trust and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Director of Corporate Governance before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

(i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example

where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

(ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

(iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

(iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Director of Corporate Governance when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a Trust Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Director of Corporate Governance.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Director of Corporate Governance, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of Trust officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy approved by the Board prohibits Board members and Trust officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or Trust officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Trust Board member or officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Director of Corporate Governance as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems

[2] The term gift refers also to any reward or benefit.

than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Trust;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Trust; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Director of Corporate Governance, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to Trust officers working within their Directorates.

8.7.2 Every Board member and Trust officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Director of Corporate Governance, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and Trust officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the Trust;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Director of Corporate Governance will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Trust to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

adequacy of the Trust's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.02. Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

9.1.1 The Director of Corporate Governance shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the Trust, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Director of Corporate Governance.

10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in

accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the Trust.

10.0.4 Whilst the Trust is not a member of WHSSC or EASC the Chief Executive does attend the Committees as an Associate Member. Assurances in respect of the functions discharged by WHSSC and EASC shall achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive.

10.0.5 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the Trust shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Board Development Programme, as part of an overall Organisation Development framework; and
- the Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Trust's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the Trust implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee or other appropriate bodies.

10.3.4 The Trust shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of citizens and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their partners.

11.0.3 The Board shall also facilitate effective scrutiny of the Trust's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the Trust, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 The Director of Corporate Governance shall arrange for a appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.

12.0.2 These SOs shall be reviewed annually by the Audit Committee [or equivalent], which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

CONTENTS

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance

The Director of Corporate Governance will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's values and standards of behaviour.

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]** of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are detailed in Schedule 2.
3	FULL	GENERAL	Approve the Trusts Governance Framework.
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the Trust's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the Trust's Values and Standards of Behaviour Framework Policy.
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Director of Corporate Governance
11	FULL	STRATEGY & PLANNING	Determine the Trust's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
13	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
14	FULL	STRATEGY & PLANNING	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
15	FULL	STRATEGY & PLANNING	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
16	FULL	OPERATING ARRANGEMENTS	Approve the Trust's framework and strategy for performance management.
17	FULL	STRATEGY & PLANNING	Approve the Trust's framework and strategy for risk management and assurance.
18	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
19	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
20	FULL	STRATEGY & PLANNING	Approve the Trusts patient, public, staff, partnership and stakeholder engagement and co-production strategies.
21	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
22	NO – Remuneration and Terms of Service Committee (For Chief Executive Committee to consist of Chair and non-Officer Members, for all other Officer members as above and to include Chief Executive)	ORGANISATION STRUCTURE & STAFFING	Appointment of the Chief Executive and Executive Directors (officer members of the Board)
23	NO – Remuneration and Terms of Service Committee (see above)	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance
24	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations
25	NO –	ORGANISATION	Consider appraisal of officer members of the Board

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
	Remuneration and Terms of Service Committee	STRUCTURE & STAFFING	
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
28	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
29	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
31	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board
32	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
33	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
34	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers
35	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Trust
36	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
37	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
38	FULL	PERFORMANCE & ASSURANCE	Approve the Trust’s audit and assurance arrangements

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
39	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
40	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate.
41	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales, etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
42	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
43	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
44	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Trusts performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
45	FULL	REPORTING	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
46	FULL	REPORTING	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. An Independent Member will be identified to be represented as members on the Board Committees/Sub Committees as outlined in Schedule 3.
	VICE CHAIR		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. An Independent Member will be identified to be represented as members on the Board Committees/Sub Committees as outlined in Schedule 3.
	CHAMPION/ NOMINATED LEAD		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. Independent Members will be identified as Champions/Leads for the following areas: • Armed Forces and Veterans • Digital • Hosted Organisations • Infection Prevention • Mental Health • Patient Information • Patient and Donor Engagement and Experience • Performance Framework • Research, Development and Innovation • Sustainable Development and Design • University Trust • Violence and Aggression • Vulnerability • Welsh Language

DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

The Board has delegated a range of its powers to the following Committees and others:

- Remuneration & Terms of Service Committee
- Audit Committee
- Quality, Safety & Performance Committee
- Strategic Development Committee
  - Transforming Cancer Services Programme Scrutiny Sub-Committee
- Charitable Funds Committee
  - Charitable Funds Investment Performance Review Sub-Committee
  - Research, Development & Innovation Sub-Committee
- Advisory Consultants Appointment Committee (to be established for each consultant medical staff appointment as appropriate to the specialist nature of the post, in accordance with guidance from Welsh Government)
- Academic Partnership Board
- NHS Wales Shared Services Partnership Committee (established as a direct result of Welsh Government regulations)
  - NHS Wales Shared Services Partnership Audit Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, set out in **[insert details]**, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Directors	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Executive Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	Directors	Yes	Authorisation matrix. Financial policies & procedures
Reimbursement of patient monies	Directors	Yes	Authorisation matrix. Financial policies & procedures
Management of Grant Agreements	Executive Director of Finance	No	Not Applicable.
Management of Legacy Income	Executive Director of Finance	No	Not Applicable.
Engagement of staff within funded establishment	Directors	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Chief Executive	Nominated deputy	In absence of Chief Executive
Staff re-grading and awarding of incremental points	Executive Director of Organisational Development & Workforce	Yes	Written authority to suitably qualified HR staff

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of overtime	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of compassionate leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of leave without pay	Directors	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Reserved for Board Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Executive Director of Organisational Development & Workforce	No	
Approval of relocation costs	Executive Director of Organisational Development & Workforce	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • Directors • Other staff	Reserved for Board Directors / Divisional Directors	No	

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of redundancy, early retirement and ill-health retirement	Chief Executive	Yes	Authorisation matrix. HR policies & procedures
Dismissal of staff	Executive Director of Organisational Development & Workforce	Yes	Authorisation matrix. HR policies & procedures
Management of clinical and other operational capacity	Directors	Yes	Authorisation matrix. Annual Operating Framework and operational plans
Approval to procure goods and services within budget	Directors	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Chief Executive	Nominated deputy	In absence of Chief Executive
Approval to commission healthcare services from other NHS bodies	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission healthcare services from voluntary sector	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission healthcare services from private and independent providers	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval to amend the drugs formulary	Executive Medical Director	No	
Approval to prescribe drugs outside the formulary	Executive Medical Director	Yes	Prescribing policies & procedures
Authorisation of sponsorship	Chief Executive	No	Sponsorship policies & procedures
Approval of clinical trials	Executive Medical Director	Yes	Clinical policies & procedures
Approval of research projects	Chief Executive	Yes	Research policies & procedures
Management of complaints	Executive Director of Nursing, Allied Health Professionals & Clinical Scientists	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	Director of Corporate Governance	Yes	Communication policies & procedures
Investment of charitable funds	Executive Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval for use of charitable funds	Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose equipment	Directors	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation (except for personal effects)	Directors	No	Within authorised limits set by WG.

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	 Small claims panel Director of Finance Chief Executive Approval by WG	 No No No No	
Approval of Clinical negligence and personal injury claims	Executive Director of Nursing, Allied Health Professionals & Health Sciences	Yes	Authorisation matrix and within limits set by WG.
Approval of staff tenancy agreements	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of capital expenditure	Chief Executive / Executive Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	Executive Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Chief Executive	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Executive Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Service Directors.
The calling down of new public dividend capital as identified in the Trust's External Financing Limit (EFL).	Executive Director of Finance	Yes	Further delegations subject to authorisation matrix. Financial policies and procedures.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Standing Financial Instructions detail the requirements for Budgetary Control, including:

- Budget Setting
- Budgetary Delegation
- Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Chief Executive will delegate the following Income and Expenditure budgetary responsibility:

- Velindre Cancer Centre budgets to Velindre Cancer Centre Divisional Director
- Welsh Blood Service budgets to Welsh Blood Service Divisional Director

In addition the Income and Expenditure budgetary responsibility for hosted organisations are delegated to the relevant Director/Senior Manager.

The Chief Executive and Divisional Directors will, in turn, delegate budgetary responsibility to other Directors and managers. The detailed schedule of this second tier delegation will be reviewed, revised and reapproved on an annual basis by the Executive Board as part of the annual Financial Strategy and Budget Setting process.

Within the budgetary delegation there are delegated powers of budget virement

- Budget virements between Divisions must be approved by the Chief Executive.
- Budget virements between budgets within the same Division must be approved by the Divisional Director.
- Budget virements between staff and non-staff within the same budget must be approved by the Budget Holder.
- These delegated powers of virement, from the Chief Executive to Divisional Directors and Budget Holders, assume that the Trust is achieving its financial targets and can be revised, in year, by the Chief Executive in the light of adverse financial performance.
- Budget virements within Divisions can be authorised by Divisional Director and Director of Finance up to the limit of £60,000.

FINANCIAL LIMITS

(All values exclude VAT)

Financial Limits	Revenue £'000	Capital £'000	Charitable Funds £'000
Corporate Services:			
Trust Board	No Limit	No Limit	0
Charitable Funds Committee	0	0	No Limit
Chief Executive	100	100	5
Cancer Services:			
Director of Cancer Services, Director of Operations & Chief Pharmacist – for Pharmaceuticals	150	0	0
Blood Wholesale Products Chief Executive Executive Director of Finance WBS Director WBS Medical Director WBS Deputy Director WBS Assistant Director of Operations	800	0	0

Further delegated financial limits which are **less than £100k** will be agreed by the Chief Executive and the Executive Management Board.

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF DELEGATION

Please refer to the Shared Services Partnership Committee Standing Orders contained within Schedule 5.

LOSSES & COMPENSATION LIMITS

NB All amounts are exclusive of VAT.	DELEGATED LIMITS							
	Trust Limit	Trust Board	Chief Executive	Director of Nursing	Director of Finance	Divisional Directors	Claims Manager / Q&S Manager	Small Claims Panel
	£	£	£	£	£	£	£	£
1. LOSSES OF CASH DUE TO:-								
a) Theft, Fraud etc.	50,000	50,000						
b) Overpayment of Salaries, Wages, Fees & Allowances	50,000	50,000						
c) Other causes, including un-vouched or completely vouched payments, overpayments other than those included under 1b; physical losses of cash and cash equivalents e.g. stamps due to fire (other than arson), accident and similar cause	50,000	50,000						
(2) FRUITLESS PAYMENTS (including abandoned capital schemes)	250,000	250,000						
(3) BAD DEBTS AND CLAIMS ABANDONED:-								
(a) Private Patients	50,000		50,000		10,000			
(b) Overseas Visitors	50,000		50,000		10,000			
(c) Causes other than a) – b)	50,000		50,000		10,000			
(4) DAMAGE TO BUILDINGS, THEIR FITTINGS, FURNITURE AND EQUIPMENT AND LOSS OF EQUIPMENT AND PROPERTY IN STORES AND IN USE DUE TO:-								
(a) Culpable causes e.g. theft, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000	50,000						
(b) Other causes	50,000	50,000						
(5) COMPENSATION PAYMENTS UNDER LEGAL OBLIGATION	FULL	FULL	100,000					
(6) EXTRA CONTRACTUAL PAYMENTS TO CONTRACTORS	50,000	50,000						
(7) EX GRATIA PAYMENTS:-								
(a) To patients and staff for loss of personal effects	50,000		50,000	50,000	10,000			1,000
(b) For Clinical Negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 (Inc. Plaintiff Costs)	>100,000 – 1,000,000	100,000	100,000	5,000	5,000		
(c) For Personal Injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 (Inc. Plaintiff Costs)	>100,000 – 1,000,000	100,000	100,000	5,000	5,000		
(d) Other clinical negligence and personal injury claims including Putting Things Right Arrangements - Concerns	50,000		50,000	50,000			5,000	
(e) Other, except cases of maladministration where there was no financial loss by the claimant	50,000		50,000	50,000				
(f) Maladministration where no financial loss by claimant	Nil							
(g) Patient referrals outside UK and EEA guidelines	Nil							
(8) EXTRA STATUTORY AND EXTRA REGULATIONARY	Nil							

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Trust framework

The Trust's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs*** *(see Schedule 2.1 below)*
- ***Standards of Behaviour Framework Policy***
- ***Trust Assurance Framework***
- ***Key policy documents***

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by the Trust intranet site or from the Director of Corporate Governance.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR NHS TRUSTS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders (incorporated as Schedule 2.1 of SOs)

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Schedule of decisions reserved to the Board and a Scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the Trust. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

Velindre University NHS Trust

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by **Velindre University National Health Service Trust** "the Trust". They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Director of Finance and Audit Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non compliance to the Director of Finance and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of NHS Trusts

1.3.1 The financial provisions and obligations for NHS Trusts are set out under Schedule 4 to the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the Trust meets its statutory obligation to perform its functions within the available financial resources.

1.3.2 The financial obligation as set out in paragraph 2 of Schedule 4 is as follows:

(1) Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

(2) Each NHS trust must achieve such financial objectives as may from time to time be set by the Welsh Ministers with the consent of the Treasury and as are applicable to it.

(3) Any such objectives may be made applicable to NHS trusts generally, or to a particular NHS trust or to NHS trusts of a particular description.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall income;

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and Trust officers, and Trust committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated to committees or sub-committees that the Trust has established or to an officer of the Trust in accordance with the 'Scheme of delegation' document adopted by the Trust.

2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that financial provisions, obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and Trust officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the Trust's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and

d) Without prejudice to any other functions of the Trust, and Board members and Trust officers, the duties of the Director of Finance include:

(i) the provision of financial advice to other Board members and Trust officers, and to Trust committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.

2.4 Board members and Trust officers, and Trust Committees

2.4.1 All Board members and Trust officers, and Trust committees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and Trust officers, and Trust committees who carry out a financial function, the form in which financial records are kept and the manner in which Trust Board members and officers, and Trust committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.
nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,

- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the Trust;

c) Access at all reasonable times to Board members and officers;

d) The production of any cash, stores or other property of the Trust under a Board member or a Trust official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the Trust. The Auditor General may nominate his representative to represent him within the Trust and to undertake the required audit work. The cost of the audit is paid for by the Trust. The Trust's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised

with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual report and accounts, is central to the core work of the Audit Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor

[1] The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs, that relate to the exercise of many of his core functions, including his statutory audits of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the Trust and its officers and staff, but also to, among others, suppliers to the Trust.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the Trust (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the Trust may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements

- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public

interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the Trust and other public sector bodies. At the Trust he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 (as amended).

https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

3.5.3 The LCFS shall report to the Trust Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Director of Finance and Audit Committee, at least annually, on proactive and reactive counter fraud work within the Trust.

3.5.5 The Trust must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The Trust should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on

NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Trust has two statutory financial duties, to:

- First Duty - A breakeven duty, to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period
- Second Duty - A duty to prepare a plan to secure compliance with the first duty and for that plan to be submitted to and approved by the Welsh Ministers

The first duty is provided for under paragraph 2(1) of Schedule 4 of the National Health Service (Wales) Act 2006, although this should be read in conjunction with 'Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts' which sets out the duty to break even over a three-year period. The second duty arises as a result of the Welsh Ministers' powers to set financial objectives for the Trust under paragraph 2(2) of Schedule 4 of the National Health Service (Wales) 2006 Act. The planning requirement, which by virtue of being set as a financial objective becomes a statutory financial duty, was previously set by the Welsh Ministers and has been retained by Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. Further details of the WHC can be obtained from the HSSG Director of Finance' hywel.jones38@gov.wales

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Trust has a statutory duty to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period, that is to breakeven over a 3-year rolling period.

4.2.2 Trusts must ensure their boards approve balanced revenue and capital plans before the start of each financial year.

4.2.3 The Director of Finance of the Trust will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total funding received, assumed in-year funding and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary funding are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year funding to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial funding and the application of such funds.

4.2.4 The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Trust has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs Trusts to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context within which the Trust will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,
  - establishing preventative approaches across all care and services
- demonstrate how the Trust will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plans should be based on a reasonable expectation of future income, service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning

document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the Trusts response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Trust plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the Trust and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1 Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focussed on delivery of safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioner, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced or specified funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents);

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

j) Identify potential risks and opportunities.

5.2 Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the

form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Director of Finance will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:
- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports

As a minimum the reports will cover:
- Current and forecast year end position on statutory financial duties
- Actual income and expenditure to date compared to budget and showing trends and run rates
- Forecast year end positions
- A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
- Explanations of material variances from plan
- Capital expenditure and projected outturn against plan
- Investigations and reporting of variances from financial, activity and workforce budgets.
- Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
- Statement of performance against savings targets
- Key workforce and other cost drivers
- Income and expenditure run rates, historic trends, extrapolation and explanations
- Clear assessment of risks and opportunities
- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and SFI 9.1.

5.4 Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the Trust's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the Trust. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.

6.3 The Director of Finance, on behalf of the Trust, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The Trust's annual accounts must be audited by the Auditor General for Wales. The Trust's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The annual report must also be sent to the Welsh Ministers. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. NHS Trusts are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Director of Finance is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Trust business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the Trust's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the Trust. No officer other than the Director of Finance shall open any account in the name of the Trust or for the purposes of furthering Trust activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the Trust and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Director of Finance will review banking arrangements of the Trust at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Director of Finance is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

e) Ensuring effective control systems are in place for the use of payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in

writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Director of Finance will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The Trust shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

9.1.2 The Trust can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The Trust should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Director of Finance when overpayment of salary or expenses have been made, in

order that recovery can be made.

9.4.3 The Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability

10.1.1. The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2. The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the Trust's scheme of delegation.

10.1.3. The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice

(whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or Trust officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

10.3.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the Trust's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Trusts must consult with NWSSP Procurement Services, Director of Finance and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Trust's Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the Trust, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money

- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Trust. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the Trust, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Contract Notification Arrangements, included as **Schedule 1** of these SFIs.

11.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Procurement Principles

11.3.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the Trust to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.3.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Equal treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Proportionality: requirements and conditions in the procurement should be reasonable in proportion to the object of procurement and measures taken should not go beyond what is necessary;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

11.4 Legislation Governing Public Procurement

11.4.1 There are a range of EU Directives which set out the EU legal framework for public procurement. These EU Directives have been implemented into UK law by statutory regulations which govern public sector procurement, the primary statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.' From 1 January 2021, all aspects of EU law in respect of the EU Directives relating to public procurement, except where expressly stated otherwise by domestic legislation, will continue to govern public sector procurement, although further amendments or developments of EU related procurement law following this will not be incorporated into domestic law. The Welsh Government policy framework and the Wales Procurement Policy Statement (WPPS) also govern this area. One of the key objectives of governing legislation is to ensure public

procurement markets are open and that there is free movement of supplies, services and works. Legislation, policy and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs.

11.4.2 The main Regulations (the Public Contracts Regulations 2015 No. 102) cover the whole field of procurement, including thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Regulations are understood and fully implemented. The protocols set out in the Regulations, and any Procurement Policy Notices, are the model upon which all formal procurement shall be based.

11.4.3 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Trust and Procurement Services e.g. Engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.4.4 Other relevant legislation and policy include:

- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Policy Framework
- The Wales Procurement Policy Statement (WPPS)

11.5 Procurement Procedures

11.5.1 To ensure that the Trust is fully compliant with UK Procurement Regulations, EU Procurement Directives and Welsh Ministers' guidance and policy, the Trust shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;
d) Evaluation and scoring methodologies
e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures shall reflect the Welsh Ministers' guidance and the Trust's delegation arrangements and approval processes.

11.6 Procurement Consent and Notification

11.6.1 Paragraph 14(2) of Schedule 3 to the National Health Service (Wales) Act 2006 allows the Trust to:

- Acquire and dispose of property;
- Enter into contracts; and
- Accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the NHS trust or for any purpose relating to the health service).

11.6.2 **Schedule 1** details the requirement process for contract notification for Trusts.

Planning

11.7 Sustainable Procurement

11.7.4 To further nurture the Welsh economy, in support of social, environmental and economic regeneration, Trusts must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible. The principles of the Well-being of Future Generations (Wales) Act 2015 (WBFGA 2015) should be adopted at the earliest stage of planning. Procurement solutions must be developed embracing the five ways of working described within the Act and capture how they will deliver against the seven goals set out in the Act.

11.7.2 The WBFGA 2015 requires that bodies listed under the Act must operate in a manner that embraces sustainability. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

11.7.3 The 7 Wellbeing goals are:

- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

These goals have been put in place to improve the social, economic, environmental, and cultural well-being of Wales.

11.7.4 Public bodies need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. The Act expects them to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place.

11.7.5 The Trust is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on Ethical Employment in supply chains which commit public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.

11.7.6 The Trust shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The Trust shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the Trust shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with Welsh Government commitments policy set out in the current WPPS and subsequent versions of this statement, the Trust shall ensure that it provides opportunities for these organisations to quote or tender for its business.

11.9 Planning Procurements

11.9.1 Trust must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks governing public procurement and the requirement of open competition.

11.9.2 Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine:

- the likely financial value of the procurement, , including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process.
- That the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement**.**

11.9.4 Where free of charge services are made available to the Trust, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Trust does not unintentionally commit itself to a single provider or longer term commitment. Regular reports on free of charge services provided to the Trust should be submitted by Board Secretary to Audit Committee.

11.9.5 Trusts are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Trust's approved

catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the table below. Trust's must ensure the value of their requirement considers cumulative spend across the Trust for like requirements and opportunity for collaboration with other Trusts and Health Boards:

11.10.3 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 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

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
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.

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

11.11.3 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable
- Specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks;
  - include robust performance measures to effectively measure and manage supplier performance; and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price;
- consider cost of change where relevant;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

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

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

11.13.2 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.

11.13.3 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.

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

11.13.5 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.

11.13.6 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.

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

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

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Trust making use of any agreements covering the disposal of such items.

11.14.3 The Trust must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the operational service of the Trust. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records;
- Monitoring contract performance measures;
- Engaging suppliers to ensure performance delivery;
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Trust budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Trusts compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract, the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Trust will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official Orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the Trust's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Trust by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Chief Executive is responsible for ensuring the Trust enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for its provision of health care services.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the Trust by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables NHS Trusts to commission certain healthcare services. Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Board reports on quality and financial performance.

13. GRANT FUNDING

It is a matter for Trusts to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the Trust's functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the Trust has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement:

Grant v Procurement.doc

13.2 Policies and procedures

13.2.1 The Trust shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Minister's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

13.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, Trusts should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money. The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on Trusts or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;

- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, Trusts should ensure principles of good practice, available from a number of external sources, are considered and reflected in grant programmes.

13.4.1 Trusts must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.2 For grant programmes that span a number of financial years, the Trust is responsible for evaluating the programmes to ensure they are fit for purpose, are achieving required outcomes and continue to provide value for money.

13.4.3 Trusts are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.4 Trusts are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the Trust to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.5 The Trust must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the Trust should ensure principles of good practice, available from a number of external sources, are considered and reflected.

13.4.6 The Trust is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs, the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment, if appropriate, approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The Trust will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e, the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or Trust official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development has responsibility for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
   - reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation);

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

14.5.3 The Chief Executive is responsible for:

a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The capital plan and programmes must be delivered within Welsh Government capital external financing limit.

15.1.2 The Director of Planning (or nominated responsible director) will develop 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. The capital programme must be affordable and within the external financing limit, as set out by Welsh Government (WG) for the year, and the Trust must not exceed the external financing limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) https://gov.wales/nhs-wales-infrastructure-investment-guidance
- Better business cases: investment decision-making framework https://gov.wales/better-business-cases-investment-decision-making-framework

15.2.2 The 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.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three year Capital Plan, and detailed annual Capital Programme is adopted by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the 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.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the Trust's SOs.

15.4.7 The Director of Planning and 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. The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The 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 Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The Trust must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 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.

15.6.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the Trust's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each

disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The 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 Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior Trust officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and Trust officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as Trust property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements including records for receipt, issues, and returns of goods to stores and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals

and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset and goods, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Director of Finance;

b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the assets and good are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately

inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The Trust must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the Trust for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology .

18.1.2 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the Trust digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the Trust's digital systems and data for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information Systems Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information Systems Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Director of Finance

18.3.1 The Director of Finance shall need to ensure that new financial data and systems and amendments to current financial data and systems are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for:

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Informatics and Digital shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the Trust arising from the use of data, information and IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 NHS Trust Responsibility

19.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Trust will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 All business shall be conducted in the name of [Insert name] National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee. SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the Trust's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The Trust shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

20.2.3 The Trust shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018 and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales, HEIW and DHCW

Our Ref: SE&IG/

Date: 31 March, 2022

Dear All,

This letter supercedes the consent guidance issued in our joint letter on 30 November 2020.

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:
- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ffôn • Tel 03000 253245
Steve.elliot@gov.wales
Gwefan • website:
www.gov.wales

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.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

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 Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

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

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;

- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

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

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

Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent.

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

Kind regards,

Steve Elliot & Ian Gunney
Cyfarwyddwr Cyllid dros dro - Interim Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

CONTENTS

Quality, Safety and Performance Committee

Terms of Reference &
Operating Arrangements

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

1. INTRODUCTION

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

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

2. PURPOSE

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

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

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance

arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

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

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

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

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

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

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

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

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

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

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

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

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

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are

maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

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

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

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

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

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

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

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

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

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

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

Authority

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

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

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

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

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

Access

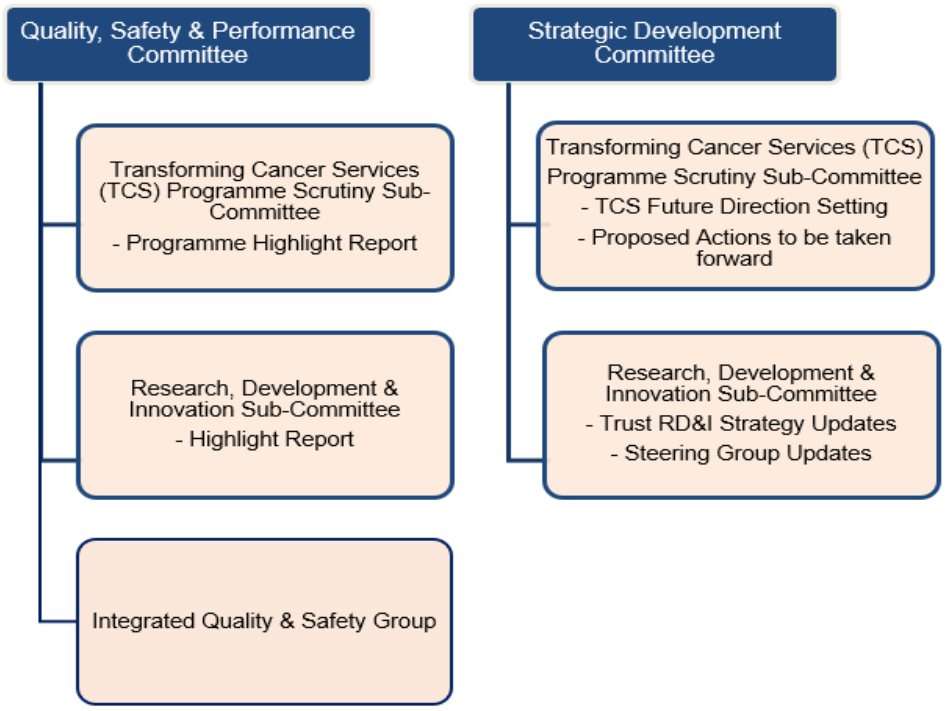
3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

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

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

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



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

4. MEMBERSHIP

Members

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

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

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

4.2 **Attendees:**

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

4.3 **By invitation**

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

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

Secretariat

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

Member Appointments

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

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

Support to Committee Members

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

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

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

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

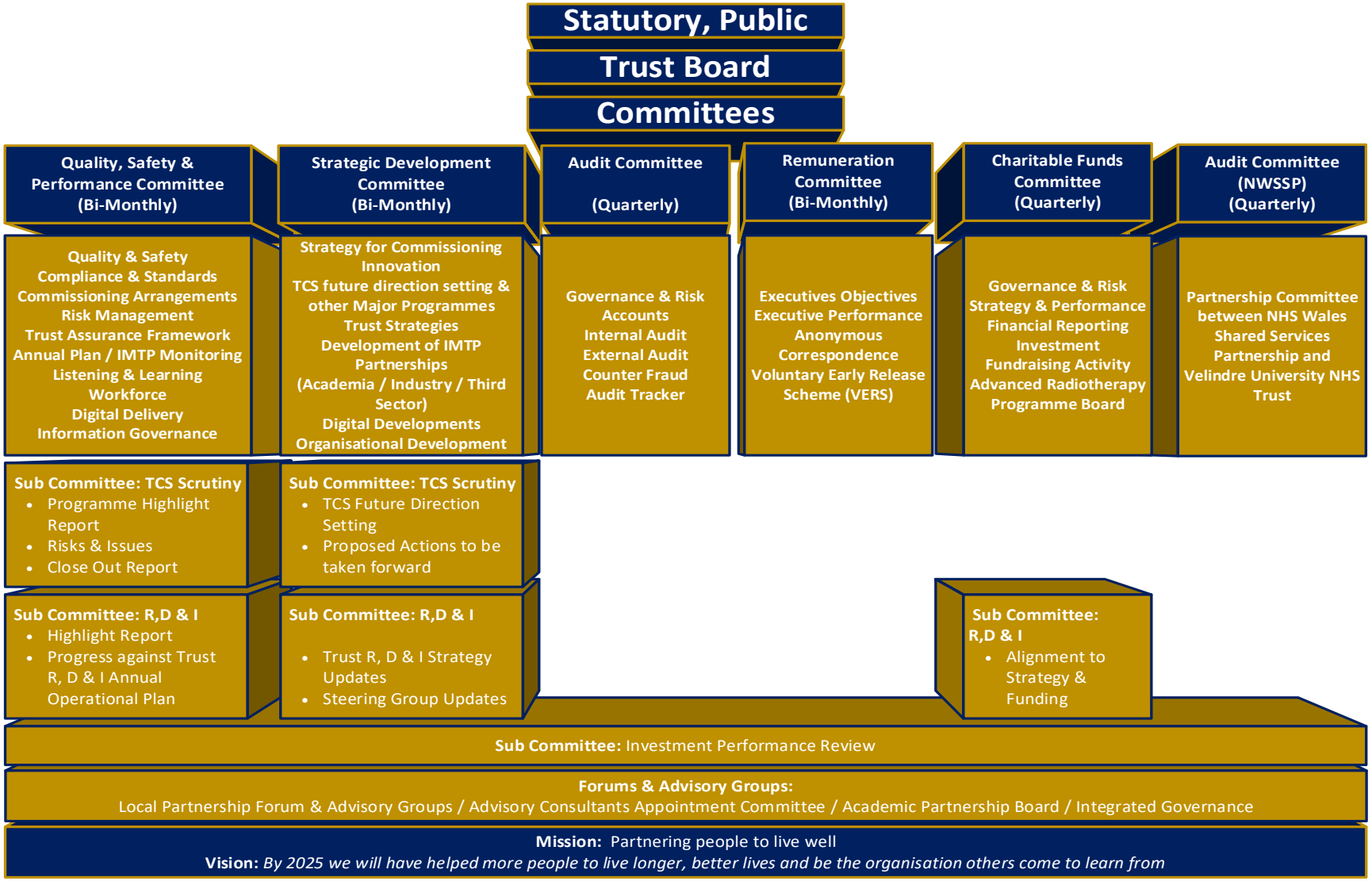
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

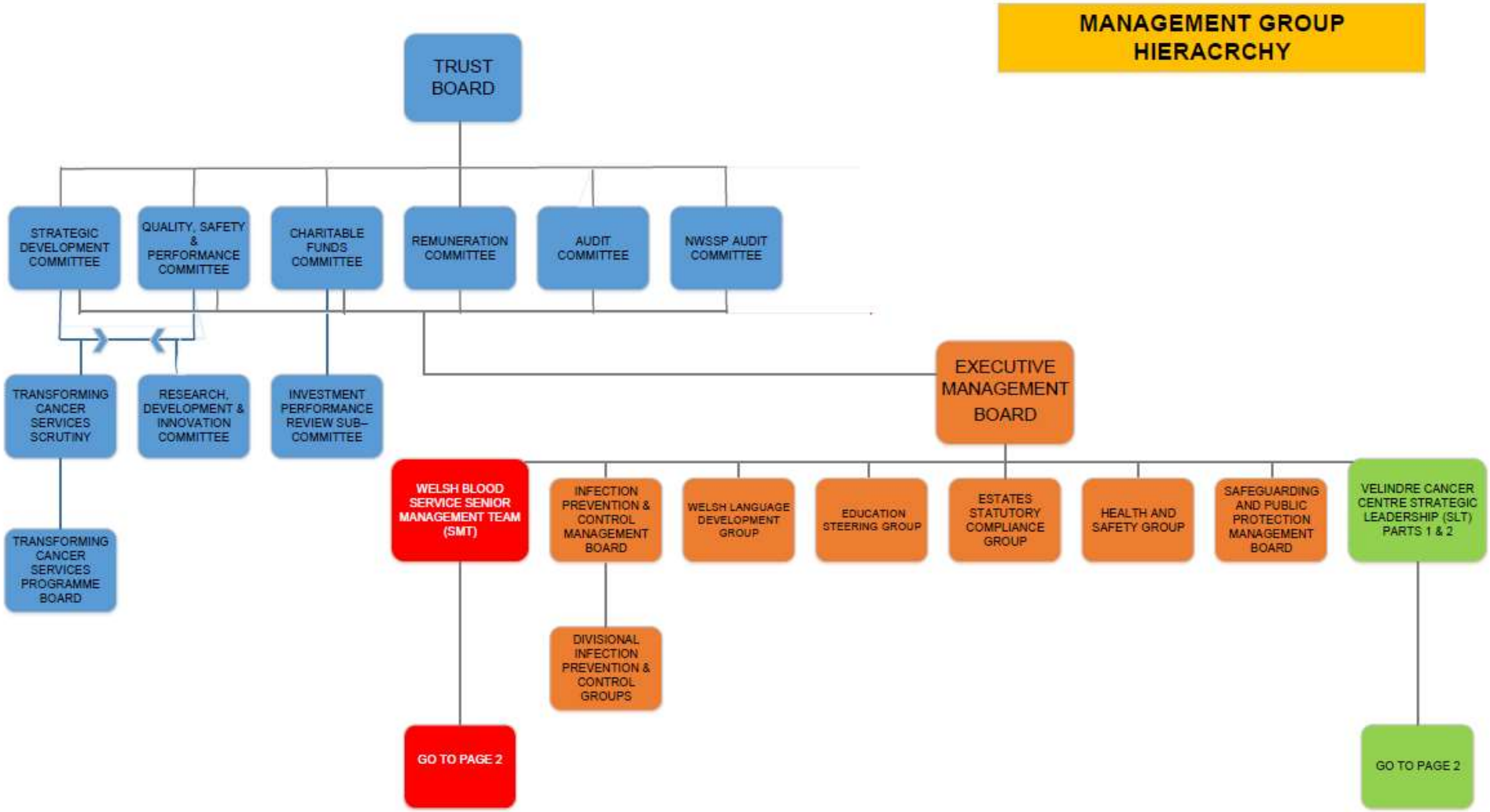
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf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

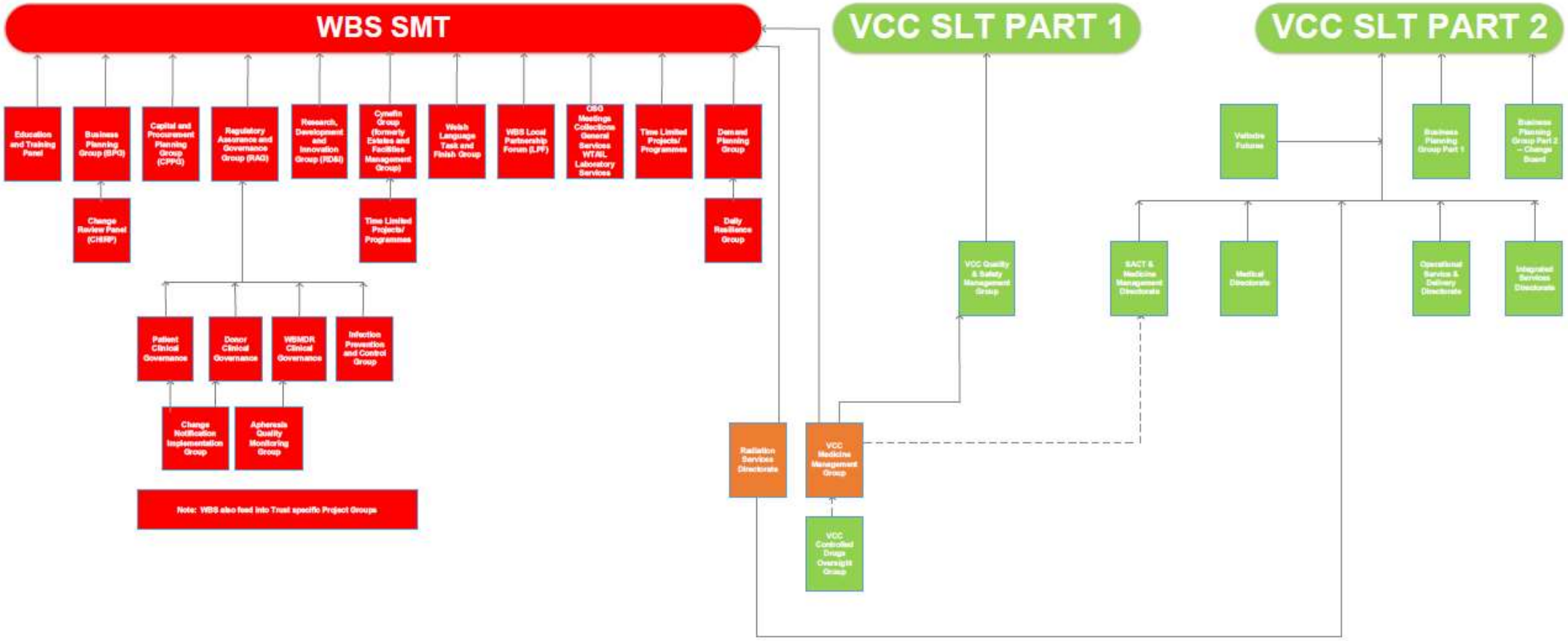
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK




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

Strategic Development Committee

Terms of Reference & Operating Arrangements

Reviewed:	October 2021
Approved:	January 2022
Next Review Due:	October 2022

1. INTRODUCTION

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

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

2. PURPOSE

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

- Evidence based and timely **advice** to the Board to assist it in discharging its functions and responsibilities with regard to the:
  - strategic direction
  - strategic planning and related matters
  - organisational development
  - digital services, estates and other enabler services
  - sustainable development and the implementation of strategy through the spirit and intention of the Well Being of Future Generations Act
  - investment in accordance with Value-based healthcare

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

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

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

- Review Trust developments involving significant investment or modernisation.

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

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

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

Authority

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

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

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

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

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

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

Access

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

Sub Committees

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

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

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

Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

4.1 **Members**

A minimum of two (2) members comprising:

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

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

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

4.2 **Attendees:**

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

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

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

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

4.3 **Secretariat**

As determined by the Director of Corporate Governance and Chief of Staff.

4.4 **Member Appointments**

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

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

4.5 **Support to Committee Members**

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

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

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

5. COMMITTEE MEETINGS

5.1 **Quorum**

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

5.2 **Frequency of Meetings**

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

5.3 **Withdrawal of individuals in attendance**

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

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

10. CHAIR'S ACTION ON URGENT MATTERS

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

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

Audit Committee

Terms of Reference & Operating Arrangements

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

1. INTRODUCTION

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

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

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

2. PURPOSE

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

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

  - the organisation's ability to achieve its objectives,

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

the Welsh Government and others,

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

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

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

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

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

- The Schedule of Losses and Compensation;

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

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

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

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

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

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

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

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

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

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

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

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

- The reliability and integrity of these assurances.

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

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

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

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

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

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

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

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that
- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

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

Authority

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

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

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

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

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

Access

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

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

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

Sub Committees

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

4. MEMBERSHIP

Members

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

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.
	The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2 In attendance:

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

By invitation — The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

Support to Committee Members

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

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5 COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

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

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

9 REVIEW

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

10 CHAIR'S ACTION ON URGENT MATTERS

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

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

Charitable Funds Committee

Terms of Reference & Operating Arrangements

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

1. INTRODUCTION

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

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

2. CONSTITUTION

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

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

3. SCOPE AND DUTIES

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

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

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

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

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

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

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

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

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

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

- Administration of all existing Charitable Funds.
- To identify any new charity that may be created (of which the Trust would also be Trustee). Ensuring that all legal requirements are followed in the creation of any new charity in order to formalise the governing arrangements.
- Provide guidelines with response to donations, legacies and bequests, fundraising and trading income.
- Responsibility for the management of investment of funds held on trust.
- Ensure appropriate banking services are available to the Trust.
- Prepare reports to the Trust Board including the Annual Accounts and Annual Report.

5. AUTHORITY

5.1 The Committee is empowered with the responsibility for:

- Overseeing the day to day management of the investments of the Charitable Funds in accordance with the investment strategy set down from time to time by the Trustees and the requirements of the Trust's Standing Financial Instructions.
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power the Committee must ensure that:

  a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
  b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
  c) The performance of the person or persons exercising the delegated power is regularly reviewed.

d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2012.
Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

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

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

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

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

- Obtaining appropriate professional advice to support its investment activities.

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

5.2 The Committee is authorised by the Board to:

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

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

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

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

5.4 **Sub Committees**

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the *'Charitable Funds Investment Performance Review Sub Committee'*, to

specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

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

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

6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

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

Attendees

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

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

By invitation, The Committee Chair may invite:

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

Secretariat

6.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

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

Support to Committee Members

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

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure and co-ordinate the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Organisational Development & Workforce.

7. COMMITTEE MEETINGS

Quorum

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

Frequency of meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

- joint planning and co-ordination of Board and Committee business; and appropriate sharing of information in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

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

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

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

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

11. REVIEW

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

12. CHAIR'S ACTION ON URGENT MATTERS

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

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

Charitable Funds Investment Performance Review Sub Committee

Terms of Reference & Operating Arrangements

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

1. INTRODUCTION

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

1.2 The Charitable Funds Committee was established by the Board to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

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

2. PURPOSE

2.1 The purpose of the Investment Performance Review Sub Committee ("the Committee") is to undertake the following tasks on behalf of the Committee:

- Ensure that when investing charitable funds Trustees achieve an appropriate balance for the Charity between the two objectives of:

  a) Providing an income to help the Charity carry out its purposes effectively in the short term; and

  b) Maintaining and, if possible, enhancing the value of the invested funds, so as to enable the Charity to carry out its purpose in the longer term.

- Ensure that the following standards as defined in **the Trustee Act are followed**, whether they are using the investment powers in that Act or not:

  a) That the Charity is discharging its general duty of care (as described in section 1 of the Trustee Act), which is the duty to exercise such care and skill as is reasonable in the circumstances. This applies both to the use of any power of investment and to the discharge of the specific duties which the Act attaches to the use of investment powers.

  b) Secondly, that the Charity is complying with the following **specific duties**:
     - Trustees must consider the **suitability** for the Charity of any investment. This duty exists at two levels. The Trustees must be satisfied that the type of any proposed investment (e.g. a common investment fund or a deposit account) is right for the Charity They also have a duty to consider whether a particular investment of that type is a suitable one for the Charity to make, based on the overall investment policy set by the Charitable Funds Committee Trustees should, at both levels, try to consider the whole range of investment options which are open to them; how far they should go here will, of course, depend on the amount of funds available for investment.

- Trustees must consider the need for **diversification**, i.e. having different types of investment, and different investments within each type. This will reduce the risk of losses resulting from concentrating on a particular investment or type of investment.

- Trustees must periodically review the investments of the Charity. The nature and frequency of these reviews is up to the Trustees to decide, but the reviews should be proportionate to the nature and size of the Charity's investment portfolio. To review too infrequently may result in losses or missed opportunities; chopping and changing investments too frequently may incur unnecessarily high levels of transaction charges. A review of the investments should be carried out at least once a year.

- Trustees must monitor the overall performance of the portfolio and, in so far as it is possible, compare the rate of return with returns achieved by other similar organisations. The rate of return will need to be reported annually to the Charitable Funds Committee as part of its annual report.

- Before exercising any power of investment, and when reviewing the Charity's investments, Trustees must obtain and consider proper **advice** from a suitably qualified adviser.

3. DELEGATED POWERS AND AUTHORITY

The Committee has delegated responsibility to the sub-committee to review the performance and strategy for the Investment Portfolio in the context of the general and specific duties set out above and has delegated the authority to investigate all relevant aspects relating to this function.

4. MEMBERSHIP

Members:

The membership of the Charitable Funds' Investments Performance Sub Committee is as follows:

- Two Independent Members of the Board (Non Executive Director)
- The Chief Executive
- The Executive Director of Finance.

One of the independent members will be Chair of the Sub-Committee.

An invitation to attend these Sub Committee meetings has been given to representatives of the Trust's Investment Management Service Provider.

Attendees:

In attendance	The Committee may require the attendance for advice, support and information routinely at meetings from: • Deputy Director of Finance • Investment Advisors

Secretariat

The Sub Committee shall be serviced by a Secretary who shall not be a member of the Sub Committee with agendas and papers circulated at least 10 working days before meetings.

5. COMMITTEE MEETINGS

Quorum: At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member.

The Sub Committee should meet every six months or as required.

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

The Sub-Committee Chair shall arrange for a report formally, regularly and on a timely basis to the Charitable Funds Committee on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports following each meeting.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Sub Committee, other than in relation to the quorum requirements as specified in 5.1 above.

9. REVIEW

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

Remuneration & Terms of Service Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Approved:	November 2020
Next Review Due:	October 2021

1. INTRODUCTION

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

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

2. PURPOSE

2.1 The purpose of the Remuneration & Terms of Service Committee "the Committee" is to provide:

- ***advice*** to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Assembly Government; and

- ***assurance*** to the Board in relation to the Trust's arrangements for the remuneration and terms of Service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales.

and to perform certain, specific functions on behalf of the Board.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Board had delegated the following specific powers to the Committee;

- To consider and ratify Voluntary Early Release scheme applications and severance payments

  in line with Standing Orders and extant Welsh Assembly Government guidance.

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

- remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Assembly Government are applied consistently;

- objectives for Executive Directors and other VSMs and their performance assessment;

- performance management system in place for those in the positions mentioned above and its application;
- proposals to make additional payments to consultants to include any additional sessions or allowances payable to Senior Medical Staff for managerial duties; and

- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Assembly Government guidance.

Authority

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

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

- any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.

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

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

Sub Committees

3.6 The Committee may, subject to the approval of the Trust Board, establish Sub Committees or task and finish Groups to carry out on its behalf specific aspects of Committee business. The following Sub Committees/task and finish Groups have been established:
None currently.

4. MEMBERSHIP

Members

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

Chair or	Vice Chair of the Board (Non-Executive Director) At least one other independent member of the Board (Non-Executive Director) The Chair of the Audit Committee (or equivalent) will be appointed to this Committee as a member

The Trust Chair may decide the business of the Remuneration & Terms of Service Committee requires the attendance of all Independent Members and as such extend an invite to all Independent Members

In attendance

4.2 By invitation

The Committee Chair may invite:

- the Chief Executive
- the Executive Director of Organisational Development & Workforce
- any other Trust officials; including a Trade Union Representative from the Trust Board and/or
- any others from within or outside the organisation
- to attend all or part of a meeting to assist it with its discussions on any particular matter (except when issues relating to their personal remuneration and terms and conditions are being discussed).

Secretariat

4.3 Secretary as determined by the Director of Corporate Governance

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements or directions made by the Assembly Government.

4.5 Members shall be appointed to hold office for any period during their appointment as Board Member of the Trust. Continued membership is subject to being a full Member of the Board.

Support to Committee Members

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

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

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

5. COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair of the Board.

Frequency of Meetings

5.2 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

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

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability in relation to its role as Corporate Trustee.

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

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

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

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework. *This will be achieved primarily through the Independent Members Group who will include 'Integrated Governance' on their agenda at least twice a year.*

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally and on a timely basis to the Board on the Committee's activities, in a manner agreed by the Board;
- bring to the Board's specific attention any significant matter under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

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

7.3 The Committee shall provide a written, annual report to the board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *[cross reference with the Standing Orders]*

9. REVIEW

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

Transforming Cancer Services Programme Scrutiny Sub-Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Approved:	November 2020
Next Review Due:	October 2021

1. INTRODUCTION

1.1 Within 3.1.1 of the Trust's standing orders it provides that *"The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".*

1.2 The Quality, Safety & Performance Committee and Strategic Development Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare and the strategic and organisational development of the Trust.

1.3 As part of their functions, the Quality Safety and Performance Committee and the Strategic Development Committee are supported by the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee to scrutinise the programme governance arrangements for the TCS Programme, which extends to its constituent projects. At a project level the Sub-Committee will examine, Project arrangements, the application and project management methodologies, monitor project performance, risk management, progress and provide assurance to the Quality, Safety and Performance Committee. Assurance on development or proposed changes to the programme scope will be provided to the Strategic Development Committee.

1.4 The detailed terms of reference and operating arrangements set by the Quality, Safety and Performance Committee and Strategic Development Committee in respect of this Sub-Committee are set out below.

2. PURPOSE

2.1 The purpose of the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee is to:

- Provide assurance that the leadership, management and governance arrangements are sufficiently robust to deliver the outcomes and benefits of the programme.
- Scrutinise the progress of the programme and provide the Trust Board with assurance that implementation is effective, efficient and within the budget available.
- Undertake any other scrutiny activity relating to the TCS Programme as directed by the Trust Board or Senior Responsible Owner (SRO).
- Seek advice and guidance from appropriate Technical Advisors as well as the MIM Transactor (if relating to the nVCC Project) to assist the Committee with their scrutiny of the TCS Programme.
- Provide assurance to the Trust Board on all aspects of the TCS Programme in relation to approvals sought on all decisions reserved for the full Board.

- Receive all audit, gateway and assurance reviews pertaining to the programme or its constituent projects and provide assurance (or otherwise) to the Trust that the programme is being delivered in accordance with all professional, financial and Trust standards.

- Provide assurance to the Trust Board and support to the Senior Responsible Officer in signalling the TCS closure activities once it has met its objectives.

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

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Trust Board, the Sub-Committee will fulfil the following functions:

3.1 Strategy and Policy Development

- Scrutinise programme and project documentation to ensure the direction of the TCS Programme remains within the scope and parameters set by the Trust Board and its alignment with the external commissioner and political environment.

- Scrutinise and provide assurance that the Programme and its constituent projects are conducted in line with the Trust's requirements on policy and legislative compliance, best practice and within the Trust's governance framework.

3.2 Governance, Monitoring and Review

The Sub-Committee will, in respect of its assurance role:

- Provide assurance that the Programme has a clear and consistent strategic direction of travel aligned with the Trust Boards requirements; strong and effective leadership; clear and transparent lines of accountability and responsibility; and effective reporting to key stakeholders and decision-makers.

- Provide assurance that Programme and Project governance arrangements are appropriately designed, proportionately applied and implemented and are operating appropriately to ensure the provision of a high quality programme and project management delivery.

- Undertake scrutiny and assurance of the Programme progress against the master programme plan, seeking explanations and remedies for any deviation from Programme timelines. It will report any concerns to the Trust Board as and when appropriate and necessary.

- Undertake scrutiny and assurance of Programme risks, issues and mitigating actions to satisfy itself that they can be placed back under the required levels of control.

- Scrutinise all sources of independent assurance in relation to the delivery of the Programme (e.g. Internal/External Audit, Independent Reviews, Gateway Reviews, CAP etc.) and scrutinise and monitor the organisation's response to independent reviews.

- Provide assurance that there are robust monitoring and management arrangements in place to identify important enablers and dependencies between the programmes projects, as failure to do so could impact on the programmes critical path.

- Scrutinise and assure that the Programme and Project expenditure against the budget allocated is appropriate and managed effectively.

3.3 **Authority**

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

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

- Other Committee, sub Committee, or group set up by the Board (including the Project Board) to assist it in the delivery of its functions.

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

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

- Provide assurance that any proposals /actual amendments to delegated limits as necessary in relation to the all TCS Projects are in accordance with the Trust Boards direction and it's Standing Orders and Statutory Financial Instructions.

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

3.4 **Access**

The Chair of the TCS Programme Scrutiny Sub-Committee shall have reasonable access to Executive Directors, Directors and other relevant staff.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members to include:

Chair	Independent member of the Board (Non-Executive Director)
	Two (2) other Independent members of the Board (Non-Executive Director)
	Other Trust Board members are extended an open invitation to attend all/any meeting

Attendees

4.2 **Core Attendance**;

- Chief Executive Officer/ Senior Responsible Owner
- TCS Programme Director
- Executive Medical Director
- Executive Director of Nursing, Therapies and Clinical Scientists
- Director of Corporate Governance
- Executive Director of Organisational Development and Workforce
- Executive Director of Finance
- Director of Commercial and Strategic Partnerships
- Director Velindre Cancer Centre
- Chief Operating Officer

4.3 **As Requested: Project Executives and other Programme / Project Staff**

- Project Executive Project 1
- Project Executive Project 2
- Project Executive Project 3
- Project Executive: Project 4
- Project Executive: Project 5
- Project Executive: Project 6

The Committee Chair may extend invitations to others from within or outside the organisation who the Committee consider should attend, taking account of the matters under consideration of each meeting.

Secretariat

4.4 As determined by the Director of Corporate Governance.

Member Appointments

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

Members shall be appointed for a maximum of 3 consecutive years before formally

reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

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

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two (2) members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or - if the Chair is not present an agreement as to who will chair from the Independent Members in their absence.

Frequency of Meetings

5.2 Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

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

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

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

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

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

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

In doing so, contributing to the integration of good governance across the Organisation,

ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Quality, Safety and Performance Committee, the Strategic Development Committee Board and the Accountable Officer on the Sub-Committee's activities. This includes verbal updates on activity and the submission of written highlight reports by exception throughout the year and an annual Committee report.

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum – as per section 5.1 above. Cross referenced with the Trust Standing Orders.

9. REVIEW

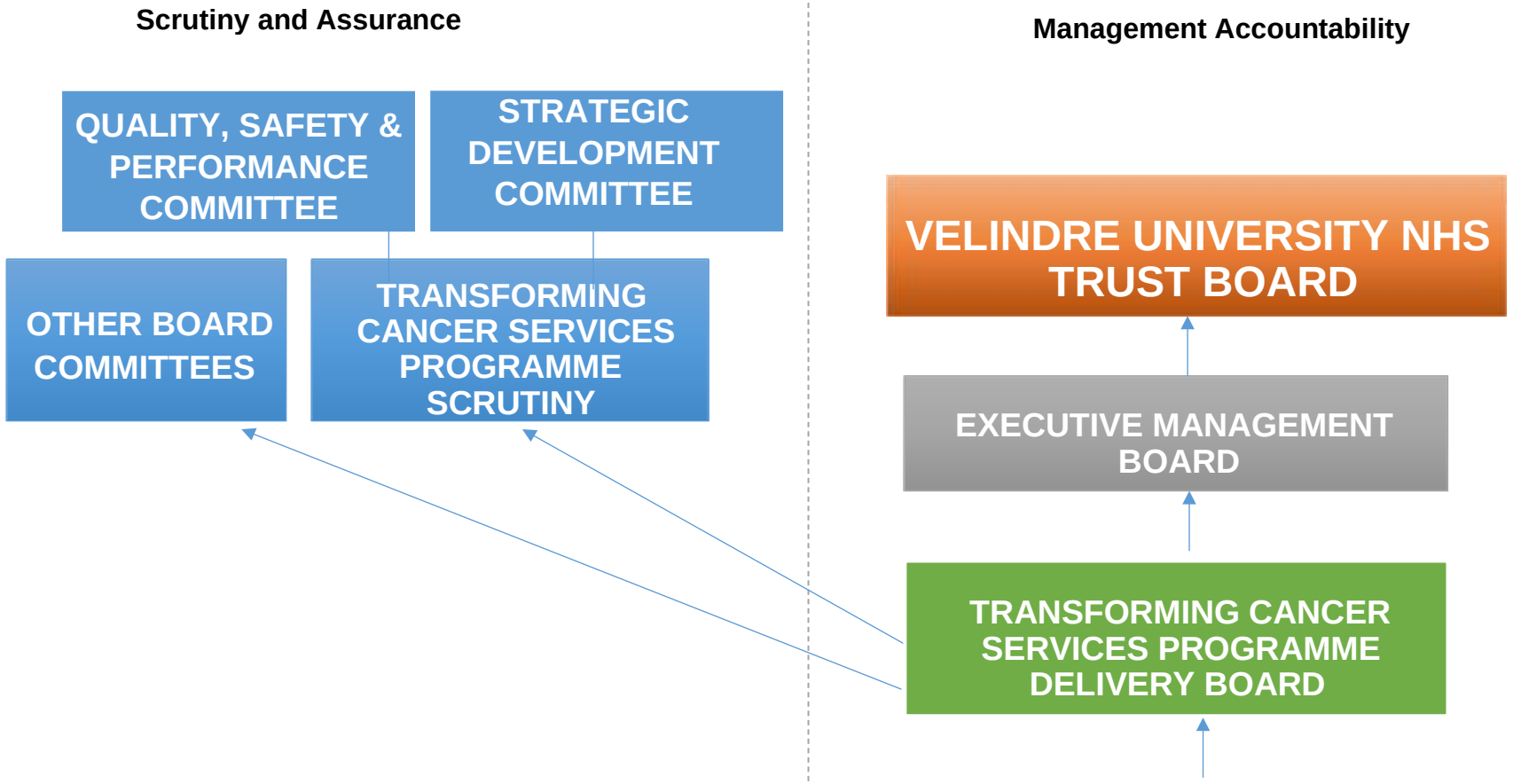
9.1 These Terms of Reference shall be reviewed annually by the Sub-Committee with reference to the Trust Board.

10. CHAIR'S ACTION ON URGENT MATTERS

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

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

Structure and governance arrangements



Research, Development & Innovation (RD&I) Sub-Committee

Terms of Reference & Operating Arrangements

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

1. INTRODUCTION

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

1.2 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.

1.3 As part of the aforementioned Committee functions, the **Research, Development & Innovation (RD&I) Sub-Committee** has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:

- oversee and maintains oversight of the RD&I Strategy on behalf of the Strategic Development Committee.
- oversee the development of an annual implementation plan that operationalises the Strategy and monitor the Division's performance and delivery on behalf of the Quality, Safety & Performance Committee.
- review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.

1.4 Research, Development and Innovation are defined as follows:

- **Research and Development**, from a healthcare perspective - refers to systematic investigation and study to generate new knowledge and insight to drive improved patient care.
- **Innovation**, from a healthcare perspective - refers to the application of original research into new or improved health policies, practices, systems, products and technologies, services or delivery methods for improved patient outcomes.

2. PURPOSE

2.1 The purpose of the RD&I Sub-Committee is to:

- Provide strategy and policy oversight for RD&I activities undertaken by the Trust reporting to the Strategic Development Committee.

- Provide assurance on the performance of RD&I activity reporting to the Quality, Safety & Performance Committee.

- Promote and encourage a RD&I ethos and culture which is integral to the Trusts vision, mission and values including the identification of new and enhanced funding opportunities to grow the significance and reach of the Trust's RDI activities.

- Provide assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the UK Policy Frameworks for Health & Social Care Research as amended from time to time.

- Consider relevant matters with reference to the parameters identified for risk appetite in relation to RD&I as set by the Board.

- The RD&I Sub-Committee is underpinned and informed through the work of a number of Management Groups and Assurance Processes as set out in ***Appendix 1***.

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Board, the Committee will fulfil the following functions:

3.1 Strategy & Policy Development

- Promote and encourage a RD&I ethos and culture within the Trust.

- Oversee the development of all RD&I strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of RD&I activity.

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

- Ensure that matters of strategic development are escalated as appropriate to the Trust Strategic Development Committee and on to Trust Board for assurance and approval as required.

3.2 Strategy & Policy Approval

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

- Scrutinise RD&I Business cases for any legal and / or ethical implications that need to be considered, access, finance and ensure alignment with the Trust overarching ten year strategy ***'Destination 2032'*** including the benefit / impact it will make for patients / donors / staff and service users. The Committee is also supported by the Advancing Radiotherapy Fund (ARF) Programme Board, (established to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales), in scrutinising bids for funding for business case proposals and will assess, review and advise as appropriate.

3.3 **Monitoring and Review**

- The Sub-Committee will, in respect of its assurance role, seek assurance that research governance and innovation arrangements are appropriately designed, implemented and are operating appropriately to ensure the provision of a high-quality RD&I service.

- To achieve this, the Sub-Committee will need assurance that the following aspects of RD&I are being effectively managed:

    - The safety, rights, dignity and wellbeing of participants in Innovation and Research development projects is above all other considerations.

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

    - The diversity of the organisation's patients, service users, donors and staff are valued and that their active involvement in the development of Research, Development and Innovation as appropriate.

    - There is close collaboration with partner Organisations in higher education to improve quality, promote joint working for best RD&I outcomes and avoid unnecessary duplication of functions. In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board.

    - The organisation ensures compliance with appropriate legislation and regulation such as the, UK Policy Framework for Health and Social Care Research 2017 the EU Clinical Trials Directive 2004 as amended, Good Laboratory Practice, Good Manufacturing Practice in manufacturing products for clinical trials and Good Clinical Practice in the conduct of all clinical Research and Innovation activities as appropriate.

    - Systems are in place to monitor compliance with regulatory requirements of the Trust as well as organisational standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Research and Innovation activity.

    - Research and Innovation investment and expenditure is accounted for and complies with audit requirements as well as the requirements of external funders or sponsors as appropriate.

    - The Committee will scrutinise research and/or innovation proposals and/or business cases that are seeking charitable funding PRIOR to submission to the Charitable Funds Committee, in order to provide assurance on the quality and safety of RD&I related activity.

    - When research or innovation findings have commercial potential, the Trust takes action to protect and exploit them in collaboration with its Research and Innovation partners and where appropriate commercial Organisations.

3.4 **Access**

The Chair of the RD&I Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

4. MEMBERSHIP

Members

4.1 A minimum of two (3) members to include:

Chair — Independent member of the Board (University) or delegated Independent Board member
Two Independent Members of the Board

Attendees

4.2 In attendance

- Executive Director with responsibility for RD&I currently Medical Director
- Executive Director of Finance or nominated officer with RD&I funding responsibilities
- Associate Medical Director with responsibility for R&D
- Clinical Director (or Nominated Deputy) – Velindre Cancer Centre
- Executive Director of Nursing AHP and Health Sciences
- Director of Corporate Governance
- Trust Head of Innovation
- Head of Velindre Cancer Research Strategy
- Trust Head of Research & Development
- Research Delivery Manager
- Research, Development and Innovation Finance Business Partner
- Representative - Velindre Cancer Centre Strategic Leadership Team
- Representative – Welsh Blood Service SMT Lead for RD&I
- Representative – Welsh Blood Service Lead Clinician for RD&I
- WBS RD&I Facilitation Lead
- Service User/Lay Representatives

4.3 **By invitation**

The Sub-Committee Chair may extend invitations as required to the following:

- Head of Information Governance (in advisory capacity)
- Divisional Directors
- Representatives of stakeholder organisations

As well as others internal or external to the Organisation who the Sub-Committee consider should be in attendance, taking account of the matters under consideration at each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

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

4.6 **Support to Committee Members**

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

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

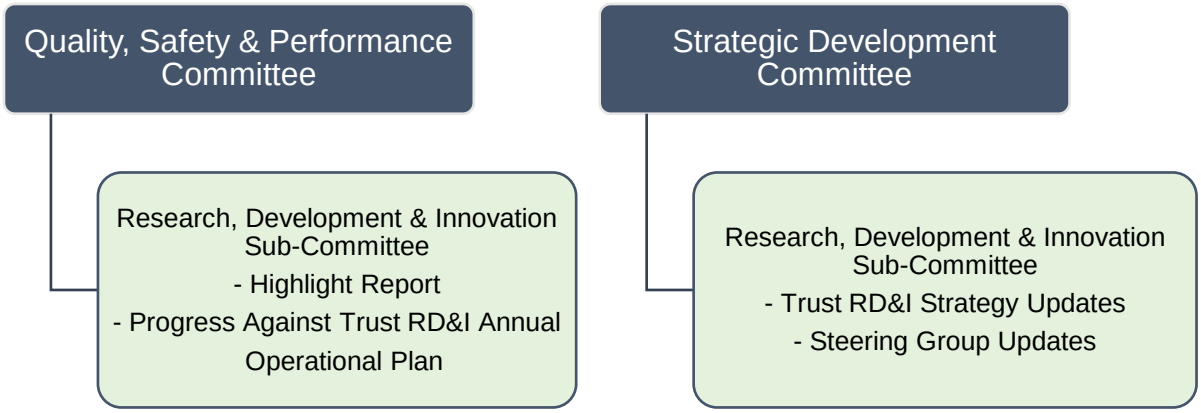
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. SUB-COMMITTEE MEETINGS

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

- Research, Development & Innovation Sub-Committee

The Sub-Committee will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as follows :



Although the Research, Development & Innovation Sub-Committee, is a sub-committee with dual reporting lines, it will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee is also accountable to the Trust Charitable Funds Committee in relation to ensuring business cases are aligned with RD&I strategy and Trust's strategic objectives. Further details are set out in each of the respective Terms of Reference. In addition, the wider governance and accountability reporting arrangements in place at a divisional level that feed upwards into the RD&I Sub-Committee structure are also summarised at **Appendix 1.**

5.1 **Quorum**

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

5.2 **Frequency of Meetings**

Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.

5.3 **Withdrawal of individuals in attendance**

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

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

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

6.2 The Sub-Committee is directly accountable to the Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee for its performance in exercising the functions set out in these terms of reference.

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

a. The Committee Chair shall:

Report formally, to the:

i. Quality, Safety & Performance Committee on the performance and delivery of RD&I quarterly.
ii. Strategic Development Committee Board on strategic development and updates to the RD&I Strategy quarterly and

iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives.

7.2 The Sub-Committee shall receive:

i. A briefing from the Executive Medical Director with responsibility for RD&I
ii. A quarterly RD&I Integrated Performance Report (following presentation at EMB)
iii. A quarterly Highlight Report from the Advancing Radiotherapy Fund Programme Board on the activity of the programme.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

9. REVIEW

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

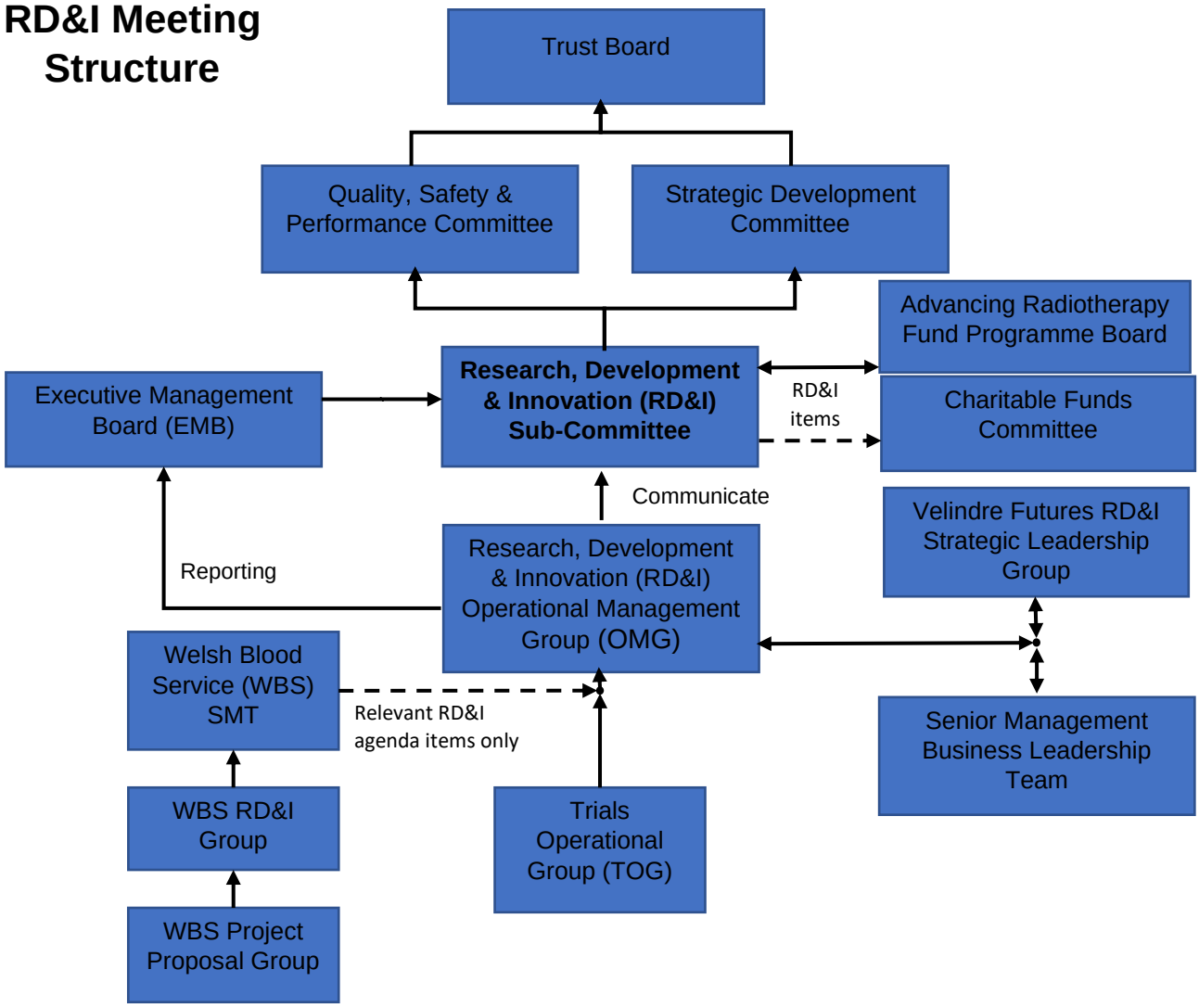
10. CHAIR'S ACTION ON URGENT MATTERS

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

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

APPENDIX 1

RD&I Meeting Structure



Schedule 4

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Terms of Reference and Operating Arrangements for;

- Local Partnership Forum
- Advisory Consultants Appointment Committee
- Academic Partnership Board

CONTENTS

Local Partnership Forum

Terms of Reference & Operating Arrangements

Reviewed:	August 2023
Approved:	September 2023
Next Review Due:	September 2024

1. INTRODUCTION

1.1 The Trust's standing orders provide for the establishment of a Local Partnership Forum (LPF) and that the Board must formally approve terms of reference and operating arrangements for the LPF.

The LPF will also operate in accordance with the Trade Union Congress (TUC) six principles of partnership working, namely;

- A shared commitment to the success of the organisation.
- A focus on quality of working life.
- Recognition of the legitimate roles of the employer and trade union.
- A commitment by the employer to employment security.
- Openness on both sides and willingness by the employer to share information and discuss future plans of the organisation.
- Adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees.

1.2 The detailed terms of reference and operating arrangements set by the Board in respect of this forum are set out below.

2. PURPOSE

2.1 The purpose of the Local Partnership Forum (LPF) is;

To provide a formal mechanism where the Trust, as employer and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

2.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

2.3 The Trust may specifically request advice and feedback from the LPF on any aspect of its business and the LPF may also offer advice and feedback even if not specifically requested by the Trust. The LPF may provide advice to the Board:

- In written advice or
- In any other form specified by the Board.

3. MEMBERSHIP

Joint Chairs

3.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the Board.

The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by the Trust.

Joint Vice Chairs

3.2 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

Each Vice Chair shall deputise for their Chair in that Chair's absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

3.3 Membership of the LPF comprises;

	Staff Representative	**Management Representative**
Joint Chair	TBC	Executive Director of Organisational Development & Workforce (WF&OD)
Joint Vice Chair	TBC Staff Rep	Chief Executive
	All accredited staff reps within the Trust	Deputy Director of OD & Workforce
		Executive Director of Finance
		Executive Director of Nursing, Allied Health Professionals and Health Science
		Chief Operating Officer
		Director VCC
		Director WBS

All members of the LPF are full and equal members and collectively share responsibility for its decisions.

All members must:

- Be prepared to engage with and contribute to the LPFs activities and in a manner that upholds the standards of good governance set for the NHS in Wales.
- Comply with their terms and conditions of appointment.
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes and
- Promote the work of the LPF within the professional discipline they represent.

Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF and their attendance has been agreed by the Joint Chairs/Vice Chairs prior to the meeting.

Appointment and Terms of Office

3.4 Management representative members shall be determined by the Board.

Staff representatives shall be determined by the staff organisations recognised by the Trust, subject to the following conditions:

- Staff representatives must be employed by the Trust and accredited by their respective trade union and
- A member's tenure of appointment will cease in the event that they are no longer employed by the Trust or cease to be a member of their nominating trade union.

The Management Representative Chair shall be appointed by the Board.

The Staff Representative Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Chair's term of office shall be for one (1) year.

The Management Representative Vice Chair shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

The Staff Representative Vice Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Vice Chair's term of office shall be for one (1) year.

A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

Removal, suspension and replacement of members

3.5 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from officer unless they are satisfied that:

(a) The absence was due to a reasonable cause and
(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

If the LPF considers that it is not conductive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

3.6 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

3.7 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4. SUB FORA

4.1 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas: and or
- Detailed discussion in relation to a specific issue(s).

Sub fora that have been established;

- The LPF Policy Sub-Group.

5. MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the LPF, one of whom should be the Management Chair or Vice Chair or the staff representative Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held quarterly or otherwise as the Joint Chairs deem necessary. Where joint Chairs agree, an extraordinary meeting of the LPF may be scheduled with 7 calendar days notice.

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

6.1 The LPF's main link with the Board is through the Executive Members of the LPF.

6.2 The Board may determine that designated Trust Members or staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Trust members or staff, subject to the agreement of the Trust Chair.

6.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

6.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

6.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

7. SUPPORT TO THE LPF

7.1 The LPF's work shall be supported by two designated Secretary's one of whom shall support the staff representative members and one shall support the management representative members.

7.2 The Director of Workforce and OD will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

7.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representatives.

7.4 Both Secretaries shall work closely with the Trust's Board Secretary who is responsible for the overall planning and co-ordination of the Trust's programme of Board business, including that of its Committees and Advisory Groups.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Joint Chairs shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the LPF's activities. This includes verbal updates on activity and the submission of written Highlight Reports.
- The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the LPF;
- ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

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

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum – as per section 5.1 above.

Cross referenced with the Trust Standing Orders.

10. REVIEW

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

11. CHAIR'S ACTION ON URGENT MATTERS

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

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

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

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid ‘put downs’ of views or points made by colleagues
- Respect a colleague’s point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No ‘side-meetings’ to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

Advisory Consultant Appointment Committee

Terms of Reference and Operating Arrangements

1. INTRODUCTION

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

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

1.3 These Terms of Reference and Operating Arrangements are based on and compliant with the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005.

1.4 Due to the nature of the business considered by the Committee, all relevant paperwork will be kept confidential and not routinely published.

2. PURPOSE

2.1 The arrangements for appointments to NHS Consultant posts are stipulated in statutory regulations: "The NHS (Appointment of Consultants) Regulations 1996", as amended. These are supported by "The National Health Service (Appointment of Consultants) Regulations Good Practice Guidance", published by the Department of Health in January 2005.

2.2 The regulations provide for appointments to be made via Advisory Appointments Committees (AACs).

3. DELEGATED POWERS AND AUTHORITY

3.1 The Trust Board has delegated to the Committee the authority to make decisions on all appointments and for appointments to be reported to the Trust Board at a subsequent meeting where the decision to appoint is unanimous. Cross reference section 5.5 and Annex B of the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005

3.2 If the Committee cannot make a unanimous decision, the majority recommendation will be referred to the Trust Board for ratification, before an offer of appointment is made.

4. MEMBERSHIP

4.1 The NHS (Appointment of Consultants) Regulations 1996 set out the governing membership for the AAC. In meeting these provisions the Trust should seek to secure a balanced Committee.

4.2 An outgoing consultant should not be a member of the Committee set up to select his/her successor.

4.3 Particular care needs to be taken in relation to Committee membership when appointing to posts across two or more Trusts, or to appointments made in conjunction with universities. For example, it is possible to contract an employee jointly between two Trusts. When constituting the AAC in such cases, the requirements in the Regulations for joint appointments will need to be met.

4.4 Trusts must ensure that no close relative of any candidate or candidate's partner serves on the Committee. If it becomes apparent during the short-listing of candidates that any member of the Committee is a close relative or partner of a candidate, that member should be invited to stand down and a replacement nomination sought.

4.5 Occasionally, one of the candidates will be well known to the 'local' members of the Committee. Such prior experience must not be allowed to interfere with an objective assessment of the candidates. A member may also have provided a reference for a candidate. On such occasions, the member must declare an interest and be careful not to show a bias.

4.6 The core membership of the Committee, as specified in Regulations, is set out below:

Chair	Chairman of the Board (Independent Member)
Members	Chief Executive Officer

Medical Director (Clinical Director to deputise in their absence)

Clinical Director or Consultant from relevant specialty as their deputy.

External Professional Assessor from the College or University.

4.7 The Trust is free to add additional members, but the balance of the Committee must continue to have local and a medical majority. The Trust must seek to ensure that the size of the Committee is, in all cases, kept to a minimum.

Attendees

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

- Faculty Consultant Lead
- Executive Director of Workforce & Organisational Development
- Trust Secretary
- Assistant Director of Research & Development

Secretariat

4.9 Secretary as determined by the Medical Director or the Executive Director of Workforce & Organisational Development who is involved in the recruitment procedure. Cross-reference section 4.9 of the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005.

Member Appointments

4.10 Appointed Independent Members shall hold office for a period that corresponds with their appointment to the Trust Board.

Support to Committee Members

4.11 The Executive Director of Workforce & Organisational Development, on behalf of the Committee Chair, shall:

- Ensure all Committee members receive the NHS Appointment of Consultants Regulations outlining their individual and collective role on the Committee.

- Retain all records and documents in connection with the short-listing and interviewing, including formal records of the decision and informal notes taken by members of the Committee, for a minimum of five years,

confidentiality being secured in case an applicant were to bring a claim against the Trust (e.g. alleging discrimination), as an employment tribunal may require these papers.

- Ensure all members of the Committee will have received appropriate training. It is the responsibility of the Trust to ensure that training has been provided. This should cover all aspects of the appointments process and concentrate on those areas where difficulties may arise:
    - Equal opportunities (refer to Annex E of the guidance)
    - Matters which should not be discussed at the interview other than in exceptional circumstances.

4.12 The role of the Board Secretary shall be to:

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

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

5. COMMITTEE MEETINGS

Quorum

5.1 The Committee may not proceed if any core member (or their appointed deputy) is not present.

5.2 Prospective members of the Committee should notify the Trust immediately they become aware they are no longer able to attend the Committee on the set date. The Trust should then find an appropriate replacement.

Frequency of meetings

5.3 Meetings shall be held as required to ensure support to the timely recruitment of consultants and otherwise as the Committee Chairs deems necessary.

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

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

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

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

- appropriate sharing of information

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 A brief report of the Committee should be prepared and signed by the Chair.

7.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board via the Workforce & Organisational Development Committee and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of Committee minutes and written reports as necessary throughout the year.

7.2 The Trust Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

7.4 Formal records of the decision made by the Committee should be retained for a minimum of five years, confidentiality being secured.

7.5 Due to the nature of the business considered by the Committee, all relevant paperwork will be kept confidential and not routinely published.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum
- Chairs Action on Urgent Matters

Cross reference with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the NHS (Appointment of Consultants) Regulations and the Board.

Academic Partnership Board

Terms of Reference and Operating Arrangements

1. INTRODUCTION

1.1 The Trust's Establishment (Amendment) Order, 2018 no.887 (W.176) established Velindre NHS Trust as Velindre University NHS Trust. This development acknowledges the Trust as *'…having a significant teaching commitment by virtue of paragraph 5(3)(b) of Schedule 3 to the National Health Service (Wales) Act 2006'.*

1.2 The Trust is committed, by way of holding University Status, to ensure one of the Non-Executive Directors (Independent Members) is appointed from Cardiff University.

1.3 The Trust has made a commitment to recognise the importance of partnership working across all academic partners and has established an **Academic Partnership Board (APB)** to support these partnerships and hereby sets out the formal terms of reference and operating arrangements.

1.4 The APB will provide a formal mechanism whereby a strategic approach will be taken to steer future operational collaboration with academic partners. The collaboration, overseen by the APB should be of mutual benefit and support in order to promote the health, wellbeing, education and economic regeneration to the benefit of the Trust's service users and the wider population of Wales.

1.5 The collaboration will be driven by a shared commitment to ensure excellent health, medical care, research, innovation, wellbeing and health care education. The parties recognise that there are synergies between them that will allow the development and promotion of the Trust's University status and provide positive opportunities for collaboration which potentially exceed the traditional University Hospital model.

1.6 The APB will operate in accordance with the following principles;

- Commitment to facilitate discussion

- Create an environment to identify, support and allow collaboration to flourish
- Realise opportunities in partnership working to enhance;

    - education, research and development across all disciplines (including engineering, maths, business, medicine, health sciences and biosciences);
    - translating research and learning into practice;
    - continuing professional development (CPD);
    - audit;
    - innovation and commercialisation;
    - modernisation and service improvement including technological developments;
    - international bench-marking;
    - wealth creation;
    - funding and grant capture; and
    - workforce modernisation/reconfiguration and training/education for newly emergent roles

2. PURPOSE

2.1 The Partnership Board is responsible for strategic collaboration between Velindre University NHS Trust and academic partners to provide and strengthen safety and quality and gain an international reputation for excellence and innovation.

2.2 The purpose of the APB is to:-

2.2.1 Ensure that the Memorandum of Understanding between the parties to which these Terms of Reference form an Annex, is fully enacted to support the services provided by the Trust achieve the highest standards of health, clinical care, research, innovation and health care education and training.

2.2.2 Promote collaborative efforts to improve the health, wellbeing, education and wealth of patients, service users and the population.

2.2.3 Review the strategic aims and objectives of each of the partners and where those aims and objectives appear to be usefully aligned, to optimise the benefits to patient care and health care service delivery through an inclusive and supportive approach.

2.2.4 Accelerate the translation of discoveries to drive improvements in quality and productivity.

2.2.5 Become a national and international exemplar for effective strategic and operational collaboration between the local health service and its partner universities.

2.2.6 Provide a broad horizon-scanning function in those areas of activity for which the APB has responsibility.

2.2.7 Foster a forward-looking organisational culture across all partners which: -

a) promotes quality improvement across all activities;
b) is rich in educational activities and staff development opportunities;
c) helps attract and retain the very best staff, including internationally leading clinical academics;
d) facilitates research grant capture by clinicians and academics and the translation of research findings into practice;
e) encourages innovation and modernisation;
f) encourages multi-disciplinary work and access to new and emergent fields of research and evidence based practice;
g) builds capacity for translational research that allows all parties to compete at an international level;
h) integrates education, research and practice that looks beyond targets and entrenched ways of working, fostering a culture of learning and innovation;
i) facilitates wealth and economic growth in the region and beyond;
j) Supports the capture and analysis of the service user experience;
k) Develops health informatics opportunities to achieve their potential;
l) Supports strategic planned lines of enquiry enabling knowledge creation.

2.2.8 Receive assurance that projects in which the parties are currently collaborating have appropriate agreements which detail the projects and clearly reflect the responsibilities of the parties. Depending on the nature of the projects the risk to the parties should be understood and the appropriate mitigated action taken.

2.2.9 The work of the Board will focus on healthcare professional education and training, continuing professional development, scholarly enquiry and research, audit and evaluation.

3. ROLE

3.1 The Partnership Board will;

3.1.1. Explore opportunities for the further development of collaborative activities between the members of the partnership - especially in relation to clinical services, research, teaching, innovation and improvement, providing advice thereon to appropriate decision- making bodies;

3.1.2. Advise on matters relating to resources for existing or potential collaborative activity;

3.1.3. Build on existing work in developing opportunities for widening access and

increasing participation in health and social care education amongst local communities;

3.1.4. Explore opportunities for the development of collaborative activities in relation to research and to promote and plan for synergy in research;

3.1.5. Maximise the benefits of shared resources and expertise;

3.1.6. Monitor and facilitate the delivery of all aspects of undergraduate teaching and postgraduate training as delivered by the members of the partnership;

3.1.7. Promote excellence in education and training to develop a workforce with the capability and commitment to transform healthcare;

3.1.8. Build capacity for translational research across the integrated patient pathway that allows the University Trust to compete at an international level;

3.1.9. Promote an outward-facing culture eager to build external links nationally and internationally with other clinical, academic and industrial partners;

3.1.10. Establish systems to recognise and reward innovation in education, research and practice, sharing best practice for stakeholders to learn from each other and facilitating the promotion of NHS clinicians to academic titles and academics to honorary clinical titles;

3.1.11. Establish specific task and finish groups, as necessary, to take forward any relevant initiatives;

3.1.12. Agree a forward work programme annually.

4. MEMBERSHIP

4.1. Membership of the APB will include;

- Chair, Velindre University NHS Trust (**CHAIR**)
- Executive Medical Director
- Executive Director Of Nursing, Allied Health Professions & Health Sciences
- Chief Operating Officer
- Executive Director of OD & Workforce (or their deputy)
- Clinical Director lead for Education
- Clinical Director lead for Research and Innovation
- Independent Board Member (in addition to the Chair)
- Cardiff University Nominated Representative
- Cardiff Metropolitan University Nominated Representative
- Swansea University Nominated Representative
- University of South Wales Nominated Representative

- Plus other University Representatives as the Chair of the Partnership Board and Trust Chief Executive determines.

4.2. The APB may require the attendance for advice, support and information routinely at meetings from other colleagues/bodies as appropriate, to be determined by the Partnership Board Chair.

4.3. The Partnership Board may extend invitations to staff of any partner organisation to attend meetings as required and establish any of the following in support of their business;

4.3.1. Task and Finish Groups

Secretariat

4.4. As determined by the Director of Corporate Governance

Member Appointments

4.5. The membership of the Partnership Board shall be determined by the Velindre University NHS Trust Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Partnership Board's remit.

4.6. Withdrawal of individuals in attendance

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

5. MEETINGS

Support to APB Members

The Director of Corporate Governance will;

5.1 ensure the provision of secretariat support for meetings, including that the appropriate notice of a meeting of the Board is given, accompanied by an agenda and copies of any papers to be discussed at the meeting;

5.2 ensure that the Academic Partnership Board receives the information it needs on a timely basis;

5.3 facilitate effective reporting to the respective organisation(s);

5.4 oversee a process of regular and rigorous self assessment and evaluation of the Academic Partnership Board's performance and operation.

5.5 The Chair of the Academic Partnership Board will be required to report upon the activities at public meetings of the University Trust or to community partners and other stakeholders, where this is considered appropriate.

5.6 Members of the Academic Partnership Board may nominate a suitably briefed senior officer on rare occasions to attend meetings in their absence.

Frequency of meetings

5.7 Meetings shall be held as required as the APB Chair deems necessary, aiming to meet 3 times a year as a minimum.

Quorum

5.8 A quorum shall be 2 Independent Members and 1 Executive Director of Velindre University NHS Trust, and at least 2 of the academic partner organisations listed in section 4 above (membership).

Frequency of Meetings

5.9 Meetings shall be held as required as the APB Chair deems necessary, aiming to meet 3 times a year as a minimum.

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

6.1 The APB, through its Chair and members, shall work closely with the Velindre Trust Board and academic partners through the:

- joint planning and co-ordination of Trust business; and
- appropriate sharing of information

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

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

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

7. REPORTING ARRANGEMENTS

7.1 A highlight report will be produced and presented to the University Trust Board at subsequent meetings, presented by the APB Chair.

7.2 All parties will ensure that reporting arrangements are in place to report through the appropriate structures within their respective organisations.

8. REVIEW

8.1 These terms of reference and operating arrangements shall be reviewed annually by the APB with reference to the Velindre University NHS Trust Board.

Schedule 5

STANDING ORDERS FOR THE OPERATION OF THE SHARED SERVICES PARTNERSHIP COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders

Standing Orders

Reservation and Delegation of Powers

For the

Shared Services Partnership Committee

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12(3) of the National Health Services (Wales) Act 2006. Velindre University NHS Trust (Velindre) must agree Standing Orders (SOs) for the regulation of the Shared Services Partnership Committee's (the SSPC) proceedings and business. These SSPC SOs form an Annexe to Velindre's own SOs, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Velindre University NHS Trust Shared Services (Wales) Regulations 2012 (2012/1261 (W.156)) and Velindre's Standing Order 3 into day to day operating practice. Together with the adoption of a scheme of decisions reserved to the SSPC; a scheme of delegations to Shared Services officers and others; and in conjunction with Velindre University NHS Trust Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the SSPC.

These documents, together with the Shared Services Memorandum of Co-operation dated **[June 2012]** made between the seven HBs and three NHS Trusts in Wales that defines the obligations of the eleven NHS bodies (the Partners) to participate in the SSPC and to take collective responsibility for the delivery of the services, a Hosting Agreement dated **[June 2012]** between the Partners that provides for the terms on which Velindre will host the NHS Wales Shared Services Partnership (NWSSP) and the Interface Agreement between the Chief Executive of Velindre (as the Accountable Officer for the organisation) and the Managing Director of Shared Services (as the Accountable Officer for NHS Wales Shared Services Partnership) dated **[June 2012]** that defines the respective roles of the two Accountable Officers, form the basis upon which the SSPC governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All SSPC members, NWSSP Shared Services staff and Velindre non-Shared Services staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Head of Finance and Business Improvement of the SSPC will be able to provide further advice and guidance on any aspect of the SOs or the wider governance arrangements for the SSPC. Further information on governance in the NHS in Wales may be accessed at: http://www.wales.nhs.uk/governance-emanual/standing-orders

TABLE OF CONTENTS

Section: A – Introduction

Statutory Framework

i) Velindre University National Health Service Trust (Velindre) is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (1993/2838)** (the Establishment Order).

ii) The Velindre University NHS Trust Shared Services Partnership Committee (to be known as the SSPC for operational purposes) was established under the **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 (2012/1261 (W.156))** (the Shared Services Regulations). The Shared Services Regulations define Shared Services at regulation 2 and the functions of the SSPC at regulation 4. The SSPC functions are subject to variations to those functions agreed from time to time by the SSPC**.** The SSPC is hosted by Velindre on behalf of each of the seven HBs and the three NHS Trusts (the Partners).

iii) The principal place of business of the SSPC is:

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

iv) All business shall be conducted in the name of the NHS Wales Shared Services Partnership on behalf of the Partners.

v) Velindre is a corporate body and its functions must be carried out in accordance with its statutory powers and duties. Velindre's statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006 (c.42)** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006 (c.41)** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

vi) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (1990/2024)**, as amended (the Membership Regulations) set out the membership and procedural arrangements of the Trust.

vii) Sections 18 and 19 of Annexe 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give Directions about how they exercise those functions. Trusts must act in accordance with those Directions. Velindre's statutory functions are set out in its Establishment Order but many functions are also contained in other legislation such as the NHS (Wales) Act 2006.

viii) However in some cases the relevant function may be contained in other legislation. In exercising its powers Velindre must be clear about the statutory basis for exercising such powers.

ix) Under powers in paragraph 4(1)(f) of Annexe 3 to the NHS (Wales) Act 2006 the Minister has made the Shared Services Regulations which set out the constitution and membership arrangements of the Shared Services Committee. Certain provisions of the Membership Regulations will also apply to the operations of the SSPC, as appropriate.

x) In addition to Directions the Welsh Ministers may from time to time issue guidance relating to the activities of the SSPC which the Partners must take into account when exercising any function.

xi) Velindre shall issue an indemnity to the Shared Services Chair, on behalf of the Partners.

NHS Framework

xii) In addition to the statutory requirements set out above, the SSPC, on behalf of each of the Partners, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Minister's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Assembly's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xiii) Adoption of the principles will better equip the SSPC to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiv) The overarching NHS governance and accountability framework within which the SSPC must work incorporates Velindre's SOs; Annexes of Powers reserved for the Board and Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the *'Doing Well, Doing Better: Standards*

for Health Services in Wales' and 'a Healthier Wales', the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xv) The Assembly, reflecting its constitutional obligations, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the restructured NHS in all it does.

xvi) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at:
http://www.wales.nhs.uk/governance-emanual/standing-orders

Directions or guidance on specific aspects of Trusts' business are also

issued in hard copy, usually under cover of a Ministerial letter.

Shared Services Partnership Committee Framework

xvii) The specific governance and accountability arrangements established for the SSPC are set out within the following documents (which is not an exhaustive list):

- these SSPC SOs and Annexe 1: Scheme of Powers reserved for the SSPC and Delegation to others;
- the Velindre University NHS Trust SFIs;
- a Memorandum of Co-operation that defines the obligations of the Partners to participate in the SSPC and to take collective responsibility for the delivery of the services defining the respective roles of the Partners;
- a Hosting Agreement between the Partners that provides for the terms on which Velindre will host the Shared Services;
- an Interface Agreement between the Chief Executive of Velindre (as the Accountable Officer for the organisation) and the Managing Director of Shared Services (as the Accountable Officer for Shared Services) that defines the respective roles of the two Accountable Officers; and
- an Accountability Agreement between the Chair of the SSPC and the Managing Director of Shared Services (as the Accountable Officer for the NHS Wales Shared Services Partnership).

xviii) Annexe 2 to these SOs provides details of the key documents that, together with these SOs, make up the SSPC's governance and accountability framework. These documents must be read in conjunction with these Shared Services SOs.

xix) The SSPC may from time to time, subject to the prior approval of Velindre's Board,

agree operating procedures which apply to SSPC members and/or members of the Shared Services staff and others. The decisions to approve these operating procedures will be recorded in an appropriate SSPC minute and, where appropriate, will also be considered to be an integral part of these Shared Services SOs and SFIs. Details of the SSPC's key operating procedures are also included in Annexe 2 of these SOs.

Applying Shared Services Standing Orders

xx) These Shared Services SOs (together with the Velindre University NHS Trust SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any Sub-Committees established by the SSPC, including any Advisory Groups. These Shared Services SOs may be amended or adapted for the Sub-Committees or Advisory Groups as appropriate, with the approval of the SSPC. Further details on Sub-Committees and Advisory Groups may be found in Annexes 3 and 4 of these Shared Services, respectively.

xxi) Full details of any non compliance with these Shared Services SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Head of Finance and Business Improvement, who will ask the Velindre Audit Committee to formally consider the matter and make proposals to the SSPC on any action to be taken. All SSPC members and SSPC officers have a duty to report any non-compliance to the Head of Finance and Business Improvement as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with Shared Services SOs is a disciplinary matter.**

Variation and amendment of Shared Services Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the SSPC determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the SSPC, advised by the Head of Finance and Business Improvement, shall submit a formal report to the Velindre Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the SSPC members are in favour of the amendment; or
- In the event that agreement cannot be reached, the Velindre Board determine that the amendment should be approved.

Interpretation

xxiii) During any SSPC meeting where there is doubt as to the applicability or

interpretation of the Shared Services SOs, the Chair of the Shared Services Committee shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Board Secretary Support function.

xxiv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these Shared Services SOs when interpreting any term or provision covered by legislation.

Relationship with Velindre NHS Trust Standing Orders

xxv) These Shared Services SOs form an Annexe to Velindre's own SOs, and shall have effect as if incorporated within them.

The Role of the Board Secretary Support Function

xxvi) The role of the Board Secretary Support function is crucial to the ongoing development and maintenance of a strong governance framework within the SSPC, and is a key source of advice and support to the Chair and SSPC members. Independent of the SSPC, the Board Secretary support function will act as the guardian of good governance within the SSPC and shall ensure that the functions outlined below are delivered:

- providing advice to the SSPC as a whole and to individual Committee members on all aspects of governance;
- facilitating the effective conduct of SSPC business through meetings of the SSPC, its Sub-Committees and Advisory Groups;
- ensuring that SSPC members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- ensuring that in all its dealings, the SSPC acts fairly, with integrity, and without prejudice or discrimination;
- contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- monitoring the SSPC's compliance with the law, Shared Services SOs and the framework set by Velindre and Welsh Ministers.

xxvii) As advisor to the SSPC, the Board Secretary Support function role does not affect the specific responsibilities of SSPC members for governing the Committee's operations. The Board Secretary Support role is directly accountable for the conduct of their role to the Chair of the SSPC and reports to the Managing Director of NWSSP on a regular basis.

1. THE SHARED SERVICES PARTNERSHIP COMMITTEE

1.1 Purpose, Role, Responsibilities and Delegated Functions

1.1.1 The SSPC has been established for the purpose of exercising Velindre's functions in relation to Shared Services, including the setting of policy and strategy and the management and provision of Shared Services to HBs, Trusts and Special Health Authority in Wales.

1.1.2 The purpose of the SSPC is to:

- set the policy and strategy for shared services;
- monitor the delivery of shared services through the Managing Director of Shared Services;
- seek to improve the approach to delivering shared services which are effective, efficient and provide value for money for Partners;
- ensure the efficient and effective leadership direction and control of shared services; and
- ensure a strong focus on delivering savings that can be re-invested in direct patient care.

1.1.3 The role of the Shared Services Committee is to:

- take into account NHS Wales organisations' plans and objectives when considering the strategy of Shared Services;
- encourage and support the aims and objectives of Shared Services;
- identify synergies between each of the Shared Services and ensure that future strategies incorporate synergistic opportunities;
- foster and encourage partnership working between all key stakeholders and staff;
- oversee the identification and sharing of financial benefits to NHS Wales' organisations on a fair basis that minimises administrative costs and financial transactional arrangements;
- seek to identify potential opportunities for further collaboration across the wider public sector;
- consider implications for Shared Services in relation to any reviews / reports undertaken by internal auditors, external auditors and regulators, including Healthcare Inspectorate Wales; and
- seek assurance, through the Managing Director of Shared Services on the adequacy and robustness of systems, processes, procedures and risk management, staffing issues and that risks and benefits are shared on an equitable basis in relation to Shared Services.

1.1.4 The responsibilities of the SSPC are to:

- produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual HB, Trust and Special Health Authority Integrated Medium Term Plans;
- agree on an annual basis Service Improvement Plans (prepared by the Managing Director of Shared Services) for the delivery by services;
- be accountable for the development and agreement of policies and strategies in relation to Shared Services and for monitoring the performance and delivery of agreed targets for Shared Services through the Managing Director of Shared Services;
- take the lead in overseeing the effective and efficient use of the resources of Shared Services;
- benchmark the performance of Shared Services against the best in class;
- consider extended-scope opportunities for Shared Services;
- monitor compliance of best practice within Shared Services with NHS Wales recommended best practice;
- oversee the identification and delivery of "invest to save" opportunities; and
- explore future Shared Services organisational delivery models across the NHS and the broader public sector.
- embed NWSSP's strategic objectives and priorities through the conduct of its business and in so doing, and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations (Wales) Act 2015, the Welsh Government Guidance on Ethical Procurement and the Code of Practice on Ethical Employment in Supply Chains.

1.1.5 The SSPC must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each HB and Trust shall be bound by the decisions of the SSPC in the exercise of its roles. In the event that the SSPC is unable to reach unanimous agreement in relation to the funding levels to be provided by each HB, Trust and Special Health Authority, then this matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the SSPC shall lead and scrutinise the operations, functions and decision making of the Shared Services Senior Management Team (SMT) undertaken at the direction of the SSPC.

1.1.7 The SSPC shall work with all its Partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the SSPC

1.2.1 The membership of the SSPC shall be 12 voting members, comprising:

- the Chair (appointed by the SSPC in accordance with the Chair Selection Process at Annexe 5 to these SOs):
- the Chief Executives of each of the HBs, Trusts and Special Health Authority (or their nominated representatives); and
- the Managing Director of Shared Services who has been designated as the accountable officer for shared services.

1.2.2 *Vice Chair* – The SSPC shall appoint a Vice Chair from one of the Chief Executives (or their nominated representative) SSPC members. A Vice Chair cannot be appointed if the current Chair is employed by the same Partner organisation.

1.2.3 *Nominated Representatives* – Nominated deputies for Chief Executives should be an Executive Director of the same organisation and will formally contribute to the quorum and have delegated voting rights.

1.2.4 *Co-opted Members* – The SSPC may also co-opt additional independent 'external' members from outside NHS Wales to provide specialist skills, knowledge and expertise. Co-opted members will not be entitled to vote.

1.2.5 *Attendees* – The NWSSP Director of Finance and Corporate Services / Deputy Director for Shared Services, the NWSSP Director of Workforce & Organisational Development and the Department of Health, Social Services and Children Director of Finance (or nominated representative) may attend the SSPC meetings but will not be entitled to vote. Other NWSSP Service Directors / Heads of Service may only attend SSPC meetings as and when invited.

1.2.6 Use of the Term Independent Member - For the purposes of these Shared Services SOs, use of the term 'Independent Member' refers to the non-officer members of a HB or the independent members of a Trust, or Special Health Authority.

1.3 Member and Staff Responsibilities and Accountability

1.3.1 The SSPC will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the SSPC.

1.3.2 All members must comply with the terms of their appointment to the SSPC. They must equip themselves to fulfil the breadth of their responsibilities on the SSPC by participating in relevant personal and organisational development programmes, engaging fully in the activities of the SSPC and promoting understanding of its work.

The Chair

1.3.3 The Chair of the SSPC must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the health service across Wales.

1.3.4 The Chair is responsible for the effective operation of the SSPC:

- chairing SSPC meetings;
- establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all SSPC business is conducted in accordance with these Shared Services SOs; and
- developing positive and professional relationships amongst the SSPC's membership and between the SSPC and each HB, Trust and Special Health Authority's Board.

1.3.5 The Chair shall work in close harmony with the Chief Executives of each of the HB, Trust and Special Health Authority (or their nominated representatives) and, supported by the Head of Finance and Business Improvement, shall ensure that key and appropriate issues are discussed by the SSPC in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.6 The Chair is accountable to the SSPC in relation to the delivery of the functions exercised by the SSPC on its behalf and, through Velindre's Chair, as the hosting organisation, for the conduct of business in accordance with the defined governance and operating framework.

The Vice Chair

1.3.7 The Vice Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

1.3.8 The Vice Chair is accountable to the Chair for their performance as Vice Chair.

Managing Director of Shared Services and the Chief Executive of Velindre

1.3.9 **Managing Director of Shared Services** – The Managing Director of Shared Services, as head of the Senior Management Team reports to the Chair and is responsible for the overall performance of Shared Services. The Managing Director of Shared Services is the designated Accountable Officer for Shared Services (see 1.3.11 below). The Managing Director of Shared Services is accountable to the SSPC in relation to those functions delegated to them by the SSPC. The Managing Director of Shared Services is also accountable to the Chief Executive of Velindre University NHS Trust in respect of the hosting arrangements supporting the operation of Shared Services.

1.3.10 **Chief Executive of Velindre** – The Chief Executive of Velindre University NHS Trust is responsible for the overall performance of the executive functions of the Trust and is the designated Accountable Officer for the Trust (see 1.3.11 below). As the host organisation, the Chief Executive (and the Velindre Board) has a legitimate interest in the activities of the Shared Services and has certain statutory responsibilities as the legal entity hosting Shared Services.

1.3.11 **Accountable Officers** – The Managing Director of Shared Services (as the Accountable Officer for Shared Services) and the Chief Executive of Velindre (as the Accountable Officer for the Trust) shall be responsible for meeting all the responsibilities of their roles, as set out in their respective Accountable Officer Memoranda. Both Accountable Officers shall co-operate with each other so as to ensure that full accountability for the activities of the Shared Services and Velindre is afforded to the Welsh Ministers whilst minimising duplication.

Senior Management Team

1.3.12 The Managing Director of Shared Services will lead a SMT to deliver the SSPC's annual Business Plan. The SMT will be determined by the Managing Director of Shared Services.

1.4 Appointment and tenure of Shared Services Partnership Committee members

1.4.1 The ***Chair,*** is appointed by the SSPC in accordance with the appointment process outlined in Annexe 5 and shall be appointed for a period specified by the SSPC, but for no longer than 4 years in any one term. The Chair can be reappointed but may not serve as the Chair of the SSPC for a total period of more than 8 years. Time served need not be consecutive and will

still be counted towards the total period even where there is a break in the term. Through the appointment process, the Shared Service Partnership Committee must satisfy itself that the person appointed has the necessary skills and experience to perform the duties. In accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 the first chair of the committee will be appointed by Velindre for a period of six months.

1.4.2 The ***Vice Chair*** is appointed by the SSPC from its Chief Executive (or their nominated representatives) members and shall be appointed for a period specified by the SSPC, but for no longer than 4 years in any one term. The Vice Chair may not serve as the Vice Chair of the SSPC for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in term.

1.4.3 The appointment and removal process for the Chair and Vice Chair shall be determined by the SSPC. In making these appointments, the SSPC must ensure:

- a balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the SSPC;
- that wherever possible, the overall membership of the SSPC reflects the diversity of the population;
- potential conflicts of interest are kept to a minimum;
- the Vice Chair is not employed by the same Partner organisation as the Chair; and
- that the person has the necessary skills and experience to perform the duties of the chair.

1.5 Termination of Appointment of SSPC Chair and Vice Chair

1.5.1 The Committee may remove the SSPC Chair or Vice Chair by the process outlined in Annexe 5 to these SOs if it determines:

- It is not in the interests of the SSPC; or
- It is not conducive to good management of the SSPC

for that Chair or Vice Chair to continue to hold office.

1.5.2 All SSPC members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they are applicable, and as specified in the relevant Regulations. Any member must inform the SSPC Chair as soon as is reasonably practicable

to do so in respect of any issue which may impact on their eligibility to hold office.

1.5.3 The SSPC will require its Chair and members to confirm their continued eligibility on an annual basis in writing.

1.6 Appointment of Shared Services Staff

1.6.1 The Shared Services staff shall be appointed by Velindre. The appointments process shall be in line with the workforce policies and procedures of Velindre and any directions made by the Welsh Ministers.

1.7 Responsibilities and Relationships with each HB, Trust and Special Health Authority's Board, Velindre University NHS Trust as the Host and Others

1.7.1 The SSPC is not a separate legal entity from each of the HBs, Trusts and Special Health Authority. It shall report to each HB, Trust and Special Health Authority Board on its activities, to which it is formally accountable in respect of the exercise of the Shared Services functions carried out on their behalf. Velindre's Board will not be responsible or accountable for exercising Velindre's functions in relation to Shared Services, including the setting of policy and strategy and the management and provision of Shared Services to HB, Trust and Special Health Authority. Velindre's Board, as the host organisation, shall be responsible for ensuring that the Shared Services staff act in accordance with the administrative policies and procedures agreed between Velindre and the SSPC.

1.7.2 Each HB, Trust and Special Health Authority shall determine the arrangements for any meetings with the Managing Director of Shared Services and their organisation through the SSPC.

1.7.3 The HB, Trust and Special Health Authority Chairs, through the lead Chair, shall put in place arrangements to meet with the SSPC Chair on a regular basis to discuss the SSPC's activities and operation.

2 RESERVATION AND DELEGATION OF SHARED SERVICES FUNCTIONS

Within the framework agreed by Velindre and set out within these Shared Services SOs - and subject to any directions that may be given by the Welsh Ministers - the SSPC may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the SSPC may be carried out effectively and in a manner that secures the achievement of

its aims and objectives. In doing so, the SSPC must set out clearly the terms and conditions upon which any delegation is being made.

The SSPC's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i Scheme of matters reserved to the SSPC;
ii Scheme of Delegation to Sub-Committees of the SSPC and others; and
iii Scheme of Delegation, including financial limits, to Velindre Shared Services officers and non-Shared Services officers all of which must be formally agreed by Velindre and adopted by the SSPC.

The SSPC retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's Action on Urgent Matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the SSPC need to be taken between scheduled meetings, and it is not practicable to call a meeting of the SSPC. In these circumstances, the SSPC Chair and the Managing Director of Shared Services may deal with the matter on behalf of the SSPC - after first consulting with at least one other HB, Trust or Special Health Authority Chief Executive (or their representative). The Head of Finance and Business Improvement must ensure that any such action is formally recorded and reported to the next meeting of the SSPC for consideration and ratification.

2.2 Delegation to Sub-Committees and Others

2.2.1 The SSPC shall agree the delegation of any of their functions to Sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions agreed by Velindre.

2.2.2 The SSPC shall agree and formally approve the delegation of specific powers to be exercised by Sub-Committees which it has formally constituted or to others.

2.3 Delegation to Officers

2.3.1 The SSPC will delegate certain functions to the Managing Director of Shared Services. For these aspects, the Managing Director of Shared Services, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other Velindre officers to undertake the remaining functions. The Managing Director of Shared Services will still be accountable to the SSPC for all

functions delegated to them irrespective of any further delegation to other Velindre officers.

2.3.2 This must be considered and approved by the SSPC (subject to any amendment agreed during the discussion) and agreed by Velindre. The Managing Director of Shared Services may periodically propose amendment to the Scheme of Delegation and any such amendments must also be considered and approved by the SSPC and agreed by Velindre.

2.3.3 Individual members of the Shared Services SMT are in turn responsible for delegation within their own teams in accordance with the framework established by the Managing Director of Shared Services and agreed by the SSPC and Velindre.

3 SUB-COMMITTEES

In accordance with Shared Services Standing Order 4.0.3, the SSPC may and, where directed by Velindre must, appoint Sub-Committees of the SSPC either to undertake specific functions on the SSPC's behalf or to provide advice and assurance to others (whether directly to the SSPC, or on behalf of the SSPC). Velindre's Shared Services officers should not normally be appointed as Sub-Committee Chairs. Shared Services officers may only be appointed to serve as members on any committee where that committee does not have the function of holding that officer to account.

These may consist wholly or partly of SSPC members or of persons who are not SSPC members.

3.1 Sub-Committees Established by the SSPC

The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or utilise Velindre's Committee arrangements to assist it in discharging its governance responsibilities. The SSPC shall ensure its Sub-Committee structure meets the needs of Velindre University NHS Trust, as the host organisation, and also the needs of its Partners. As a minimum, it shall ensure arrangements are in place to cover the following aspects of SSPC business:

- Quality and Safety
- Audit

3.1.1 The SSPC may make arrangements to receive and provide assurance to others through the establishment and operation of its own Sub-Committees or by placing responsibility with Velindre, as the host. Where responsibility

is placed with Velindre, the arrangement shall be detailed within the Hosting Agreement between the SSPC and Velindre as the host organisation and/or the Interface Agreement between the Managing Director of Shared Services (as the Accountable Officer for Shared Services) and Velindre's Chief Executive (as Accountable Officer for the Trust).

The SSPC has the following sub-committees:

- Velindre Audit Committee for SSPC
- Welsh Risk Pool Committee

Full details of the Sub-Committee structure established by the SSPC, including detailed terms of reference for each of these Sub-Committees are set out in Annexe 3 of these Shared Services SOs.

3.1.2 Each Sub-Committee established by or on behalf of the SSPC must have its own terms of reference and operating arrangements, which must be formally approved by the SSPC and agreed by Velindre. These must establish its governance and ways of working, setting out, as a minimum:

- the scope of its work (including its purpose and any delegated powers and authority);
- membership and quorum;
- meeting arrangements;
- relationships and accountabilities with others;
- any budget and financial responsibility, where appropriate;
- secretariat and other support;
- training, development and performance; and
- reporting and assurance arrangements.

3.1.3 In doing so, the SSPC shall specify which aspects of these Shared Services SOs are not applicable to the operation of the Sub-Committee, keeping any such aspects to the minimum necessary.

3.1.4 The membership of any such Sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the SSPC, subject to any specific requirements or directions agreed by Velindre. Depending on the Sub-Committee's defined role and remit; membership may be drawn from the SSPC or Velindre staff (subject to the conditions set in Shared Services Standing Order 3.1.5) or others.

3.1.5 Velindre's Shared Services officers should not normally be appointed as Sub-Committee Chairs, nor should they be appointed to serve as members

on any committee set up to review the exercise of functions delegated to Shared Services officers. Designated Shared Services Directors or Heads of Services or other Shared Services officers shall, however, be in attendance at such Sub-Committees, as appropriate.

3.2 Other Groups

3.2.1 The SSPC may also establish other groups to help it in the conduct of its business.

3.3 Reporting Activity to the Shared Services Partnership Committee

3.3.1 The SSPC must ensure that the Chairs of all Sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the SSPC on their activities. Sub-Committee Chairs' shall bring to the SSPC's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

3.3.2 Each Sub-Committee shall also submit an annual report to the SSPC through the Chair within 3 months of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

4 EXPERT PANEL AND OTHER ADVISORY GROUPS

4.1.1 The SSPC may appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the SSPC, including detailed terms of reference are set out in Annexe 4 of these Shared Services SOs.

4.1 Expert Panels and Advisory Groups Established by the SSPC

- Evidence-based Procurement Board

4.2 Confidentiality

4.2.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

4.3 Reporting Activity

4.3.1 The SSPC shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the SSPC on their activities. Expert Panel or Advisory Group Chairs shall bring to the SSPC's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.3.2 Any Expert Panel or Advisory Group shall also submit an annual report to the SSPC through the Chair within 1 month of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

4.3.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

4.4 Terms of Reference and Operating Arrangements

4.4.1 The SSPC and the Velindre Board must formally approve terms of reference and operating arrangements in respect of any. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.4.2 In doing so, the SSPC shall specify which aspects of these SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

4.4.3 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the SSPC, subject to any specific requirements or directions agreed by Velindre.

4.4.4 The SSPC may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the

Advisory Group may itself determine such arrangements, provided that the SSPC approves such action.

4.5 The Local Partnership Forum (LPF)

4.5.1 The LPF's role is to provide a formal mechanism where the SSPC, as employer, and trade unions/professional bodies representing NWSSP's employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the NWSSP – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the NWSSP workforce.

4.5.2 It is the forum where the NWSSP and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

4.5.3 NWSSP may specifically request advice and feedback from the LPF on any aspect of its business, and the LPF may also offer advice and feedback even if not specifically requested by NWSSP. The LPF may provide advice to the SSPC:

- In written advice; or
- In any other form specified by the Board.

4.6 Terms of Reference and Operating Arrangements

4.6.1 The SSPC must formally approve terms of reference and operating arrangements for the LPF. These must establish its governance and ways of working, setting out, as a minimum:

1.0.1

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role,responsibilities and accountability, and terms and conditions of office);
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the Board, its Committees and Advisory Groups, and other relevant local and national groups);
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support; and
- Reporting and assurance arrangements.

4.6.2 In doing so, the SSPC shall specify which aspects of these SOs are not applicable to the operation of the LPF, keeping any such aspects to the minimum necessary. The LPF will also operate in accordance with the TUC six principles of partnership working.

4.6.3 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas; and/or
- Detailed discussion in relation to a specific issue(s).

4.7 Membership

4.7.1 NWSSP shall agree the overall size and composition of the LPF in consultation with those staff organisations it recognises for collective bargaining. As a minimum, the membership of the LPF shall comprise:

- Management Representatives
- Managing Director
- Director of Finance & Corporate Services
- Director of Workforce and Organisational Development

together with the following:

- General Managers/Divisional Managers; and
- Workforce and Organisational Development staff

4.7.2 The Trust may determine that other Executive Directors or others may act as members or be co-opted to the LPF.

Staff Representatives

4.7.3 The maximum number of staff representatives shall be *agreed by the LPF* comprising representation from those staff organisations recognised by NWSSP.

In attendance

4.7.4 The Trade Union member of the Board shall attend LPF meetings in an ex officio capacity.

4.7.5 The LPF may determine that full time officers from those staff organisations recognised by the Trust shall be invited to attend LPF meetings.

4.8 Member Responsibilities and Accountability

Joint Chairs

4.8.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

4.8.2 The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework; and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the SSPC.

4.8.3 The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

4.8.4 The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by the Trust.

Joint Vice Chairs

4.8.5 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

4.8.6 Each Vice Chair shall deputise for their Chair in that Chair's absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.
1.0.2

4.8.7 The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

4.8.8 All members of the LPF are full and equal members and collectively share responsibility for its decisions.

4.8.9 All members must:

- Be prepared to engage with and contribute to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the LPF within the professional discipline they represent.

4.9 Appointment and Terms of Office

4.9.1 Management representative members shall be determined by the SSPC.

4.9.2 Staff representatives shall be determined by the staff organisations recognised by the NWSSP, subject to the following conditions:

- Staff representatives must be employed by NWSSP and accredited by their respective trade union; and
- A member's tenure of appointment will cease in the event that they are no longer employed by NWSSP or cease to be a member of their nominating trade union.

4.9.3 The *Management Representative Chair* shall be appointed by the LPF.

4.9.4 The *Staff Representative Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representative members. The *Staff Representative Chair's* term of office shall be for one (1) year.

4.9.5 The *Management Representative Vice Chair* shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

4.9.6 The *Staff Representative Vice Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Vice Chair's* term of office shall be for one (1) year.

4.9.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

4.10 Removal, Suspension and Replacement of Members

4.10.1 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

(a) The absence was due to a reasonable cause; and

(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

4.10.2 If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

4.10.3 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

4.10.4 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4.11 Relationship with the SSPC and others

4.11.1 The LPF's main link with the SSPC is through the Managerial members of the LPF.

4.11.2 The Senior Management Team may determine that designated SMT members or NWSSP staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of SMT members or Trust staff, subject to the agreement of the Chair.

4.11.3 The SMT shall determine the arrangements for any joint meetings between the SMT and the LPF's staff representative members.

4.11.4 The Managing Director shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

4.11.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

4.12 Support to the LPF

4.12.1 The LPF's work shall be supported by two designated Secretary's, one of whom shall support the staff representative members and one shall support the management representative members.

4.12.2 The Director of Workforce and OD will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.
1.0.3

4.12.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representatives. The Staff Representative Secretary's term of office shall be for two (2) years.

4.12.4 Both Secretaries shall work closely with the NWSSP Head of Finance and Business Improvement who is responsible for the overall planning and co-ordination of the programme of SMT and Committee business, including that of its Advisory Groups.

5 WORKING IN PARTNERSHIP

5.1.1 The SSPC shall work constructively in partnership with others to plan and secure the delivery of the best possible healthcare for its citizens, in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

5.1.2 The Chair shall ensure that the SSPC has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the NWSSP through:

- NWSSP's own structures and operating arrangements, e.g., Advisory Groups;

5.1.3 The SMT shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6 MEETINGS

6.1 Putting Citizens first

6.1.1 The SSPC's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The SSPC, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

1.0.4

- active communication of forthcoming business and activities;
- the selection of accessible, suitable venues for meetings;
- the availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read and in electronic formats;
- requesting that attendees notify the Committee Secretariat of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g. arranging British Sign Language (BSL) interpretation at meetings; and

where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh, in accordance with legislative requirements, e.g. Equality Act 2010 (Statutory Duties) (Wales) Regulations , Welsh Language (Health Sector) Regulations; as well as NWSSP's Communication Strategy and Velindre's Welsh Language Scheme.

6.1.2 The SSPC Chair will ensure that, in determining the matters to be considered by the SSPC, full account is taken of the views and interests of all citizens served by the SSPC on behalf of each HB, Trust and Special Health Authority, including any views expressed formally. The Chair will ensure that, in determining the matters to be considered by the Committee, full account is taken of the views and interests of the Committee's stakeholders, including any views expressed formally to the Committee, e.g. through Community Health Councils.

6.2 Annual Plan of Committee Business

6.2.1 The Committee Secretariat, on behalf of the SSPC Chair, shall produce an annual Business Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Business Plan shall also set out any standing items that shall appear on every SSPC agenda.

6.2.2 The Business Plan shall set out the arrangements in place to enable the SSPC to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing SSPC members to contribute in either English or Welsh languages, where appropriate.

6.2.3 The Business Plan shall also incorporate formal SSPC meetings, regular Committee development sessions and, where appropriate, and the planned activities of Sub-Committees, Expert Panel and Advisory Groups.

6.2.4 The SSPC shall agree the Business Plan for the forthcoming year by the end of March.

6.3 Calling Meetings

6.3.1 In addition to the planned meetings agreed by the SSPC, the SSPC Chair may call a meeting of the SSPC at any time. An individual SSPC member may request that the SSPC Chair call a meeting provided that in at least one third of the whole number of Committee members supports such a request.

6.3.2 If the Chair does not call a meeting within seven days after receiving such a request from SSPC members, then those SSPC members may themselves call a meeting.

6.4 Preparing for Meetings

Setting the agenda

6.4.1 The SSPC Chair, in consultation with the Committee Secretariat and Managing Director of Shared Services, will set the agenda. In doing so, they will take account of the planned activity set in the annual cycle of SSPC business; any standing items agreed by the SSPC; any applicable items received from Sub-Committees and other groups as well as the priorities facing the SSPC. The SSPC Chair must ensure that all relevant matters are brought before the SSPC on a timely basis.

6.4.2 Any SSPC member may request that a matter is placed on the agenda by writing to the SSPC Chair, copied to the Committee Secretariat, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of SSPC business.

Notifying and equipping SSPC members

6.4.3 SSPC members should be sent an agenda and a complete set of supporting papers at least 10 calendar days before a formal SSPC meeting. This information may be provided to SSPC members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided after this time, provided that the SSPC Chair is satisfied that the SSPC's ability to consider the issues contained within the paper would not be impaired.

6.4.4 No papers should be included for decision by the SSPC unless the SSPC Chair is satisfied (subject to advice from the Committee Secretariat, as appropriate) that the information contained within it is sufficient to enable the SSPC to take a reasonable decision. Equality Impact Assessments (EIA) shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the SSPC, and the outcome of that EIA shall accompany the report to the SSPC to enable the SSPC to make an informed decision.

6.4.5 In the event that at least half of the SSPC members do not receive the agenda and papers for the meeting as set out above, the SSPC Chair must consider whether or not the SSPC would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the SSPC Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.4.6 In the case of a meeting called by SSPC members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.4.7 Except for meetings called in accordance with Shared Services Standing Order 6.4, at least 10 calendar days before each meeting of the SSPC a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- at the SSPC's principal sites;
- on the SSPC's website, together with the papers supporting the public part of the agenda; as well as
- through other methods of communication as set out in the SSPC's communication strategy.

6.4.8 When providing notification of the forthcoming meeting, the SSPC shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g. as Braille, large print, easy read, etc.

6.5 Conducting Shared Services Partnership Committee Meetings

Admission of the public, the press and other observers

6.5.1 The SSPC shall encourage attendance at its formal SSPC meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the SSPC. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility such as an induction loop system.

6.5.2 The SSPC shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g. business that relates to a confidential matter affecting a Shared Services officer, a patient or a procurement contract. In such cases the Chair (advised by the Head of Finance and Business Improvement where appropriate) shall Annexe these issues accordingly and requires that any observers withdraw from the meeting. In doing so, the SSPC shall resolve:

"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" [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

6.5.3 In these circumstances, when the SSPC is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the SSPC in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a SSPC meeting held in public session.

6.5.4 The Head of Finance and Business Improvement, on behalf of the SSPC Chair, shall keep under review the nature and volume of business

conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.5.5 In encouraging entry to formal SSPC meetings from members of the public and others, the SSPC shall make clear that attendees are welcomed as observers. The SSPC Chair shall take all necessary steps to ensure that the SSPC's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting. In doing so, the SSPC shall resolve:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the SSPC to reconvene the meeting and to complete business without the presence of the public".

6.5.6 Unless the SSPC has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the SSPC, its Sub-Committees, Expert Panel or Advisory Groups

6.5.7 The SSPC shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the SSPC, its Sub-Committees, expert panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the SSPC will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the SSPC (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing SSPC Meetings

6.5.8 The Chair of the SSPC will preside at any meeting of the SSPC unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent then no formal business shall take place.

6.5.9 The Chair must ensure that the meeting is handled in a manner that enables the SSPC to reach effective decisions on the matters before it. This includes ensuring that SSPC members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the SSPC must have access to appropriate advice on the conduct of the

meeting through the attendance of the Head of Finance and Business Improvement. The Chair has the final say on any matter relating to the conduct of SSPC business.

Quorum

6.5.10 At least 6 voting members, at least 4 of whom are HB, Trust or Special Health Authority Chief Executives (or their nominated representatives) and one is either the Chair or the Vice Chair, must be present to allow any formal business to take place at a Shared Services Committee meeting. If the Managing Director of Shared Services is not present, then no formal business should be transacted unless there is in attendance a properly authorised deputy for the Managing Director.

6.5.11 If a HB, Trust or Special Health Authority Chief Executive (or their nominated representative) or the Managing Director of Shared Services is unable to attend a SSPC meeting, then a nominated deputy may attend in their absence which should be an Executive Director of the same organisation and will formally contribute to the quorum and have delegated voting rights, provided that the Chair has agreed the nomination before the meeting.

6.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e. any decisions to be made. Any SSPC member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.5.13 In the normal course of SSPC business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a SSPC member may put forward a motion proposing that a formal review of that service area is undertaken. The Board Secretary support role will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the SSPC unless moved by a SSPC member and seconded by another SSPC member (including the SSPC Chair).

6.5.14 **Proposing a formal notice of Motion –** Any SSPC member wishing to propose a motion must notify the SSPC Chair in writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the SSPC Chair has determined that the proposed motion is relevant to the SSPC's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the SSPC Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.5.15 The SSPC Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of SSPC business.

6.5.16 **Amendments -** Any SSPC member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the SSPC alongside the motion.

6.5.17 If there are a number of proposed amendments to the Motion, each amendment will be considered in turn, and if passed, the amended Motion becomes the basis on which the further amendments are considered, i.e. the substantive motion.

6.5.18 **Motions under discussion –** When a motion is under discussion, any SSPC member may propose that:

- the motion be amended;
- the meeting should be adjourned;
- the discussion should be adjourned and the meeting proceed to the next item of business;
- a SSPC member may not be heard further;
- the SSPC decides upon the motion before them;
- an ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.5.20 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconded and the SSPC Chair.

6.5.21 **Motion to rescind a resolution –** The SSPC may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months unless the motion is supported by the (simple) majority of SSPC members.

6.5.22 A motion that has been decided upon by the SSPC cannot be proposed again within six months except by the SSPC Chair, unless the motion relates to the receipt of a report or the recommendations of a Sub-Committee/Managing Director of Shared Services to which a matter has been referred.

Voting

6.5.23 The SSPC Chair will determine whether SSPC members' decisions should be expressed orally, through a show of hands, or by secret ballot or by recorded vote. The SSPC Chair must require a secret ballot if the majority of voting SSPC members request it. Where voting on any question is conducted, a record shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the minutes shall record the name of the individual and the way in which they voted.

6.5.24 In determining every question at a meeting, the SSPC members must take account, where relevant, of the views expressed and representations made by individuals who represent the interests of citizens in Wales. Such views may be presented to the SSPC through the Chairs of any Expert Panel, Advisory Group and/or the Community Health Council representative(s).

6.5.25 Except for decisions related to the overall funding contribution from each of the HBs, Trusts or Special Health Authority, the SSPC will make decisions subject to a 2/3 majority of voting. In no circumstances may an absent SSPC member (or their nominated deputy) vote by proxy. Absence is defined as being absent at the time of the vote.

6.6 Record of Proceedings

6.6.1 A record of the proceedings of formal SSPC meetings (and any other meetings of the SSPC where the SSPC members determine) shall be drawn up as 'minutes'. These minutes shall include a record of SSPC member attendance (including the SSPC Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the SSPC, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.6.2 Agreed minutes shall be circulated in accordance with SSPC members' wishes, and, where providing a record of a formal SSPC meeting shall be made available to the public on the Shared Services website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g. Data Protection Act, the SSPC's Communication Strategy and Velindre's Welsh Language Scheme.

6.7 Confidentiality

6.7.1 All SSPC members, together with members of any Sub-Committee, Expert Panel or Advisory Group established by or on behalf of the SSPC and SSPC members and/or HB/Trust/Special Health Authority officials must respect the confidentiality of all matters considered by the SSPC in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the SSPC Chair or relevant Sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g. in contracts of employment, within the Values and Standards of Behaviour Framework or legislation such as the Freedom of Information Act (2000), etc.

7 VALUES AND STANDARDS OF BEHAVIOUR

The SSPC must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour Framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the SSPC, including SSPC members, Velindre Shared Services officers and others, as appropriate. The Framework adopted by the SSPC will form part of these SOs.

7.1 Declaring and Recording Shared Services Partnership Committee Members' Interests

7.1.1 **Declaration of interests –** It is a requirement that all SSPC members should declare any personal or business interests they may have which may affect, or be perceived to affect, the conduct of their role as a SSPC member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the SSPC's business. SSPC members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. SSPC members must notify the SSPC of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as SSPC members.

7.1.2 SSPC members must also declare any interests held by family members or persons or bodies with which they are connected. The Head of Finance and Business Improvement will provide advice to the SSPC Chair and the SSPC on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g. the Values and Standards of Behaviour framework. If individual SSPC members are in any doubt about what may be considered as an interest, they should seek advice from the Head of Finance and Business Improvement. However, the onus regarding declaration will reside with the individual SSPC member.

7.1.3 **Register of interests –** The Managing Director of Shared Services, through the Head of Finance and Business Improvement will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all SSPC members. The register will include details of all Directorships and other relevant and material interests which have been declared by SSPC members.

7.1.4 The register will be held by the Head of Finance and Business Improvement, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by SSPC members. The Head of Finance and Business Improvement will also arrange an annual review of the register, through which SSPC members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the SSPC's commitment to openness and transparency, the Head of Finance and Business Improvement must take reasonable steps to ensure that citizens served by the SSPC are made aware of, and have access to view the Register of Interests. This will include publication on the Shared Services website.

7.1.6 **Publication of declared interests in Annual Report –** SSPC members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each Shared Services' Annual Report. For clarification, this will be included within Velindre University NHS Trust's Annual Report, as there is no requirement for Shared Services to prepare the same.

7.2 **Dealing with Members' interests during Shared Services Partnership Committee meetings**

7.2.1 The SSPC Chair, advised by the Head of Finance and Business Improvement, must ensure that the SSPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased

manner. In turn, individual board members must demonstrate, through their actions, that their contribution to the SSPC's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the SSPC and as a member of the Board of an HB, Trust or Special Health Authority.

7.2.2 Where individual SSPC members identify an interest in relation to any aspect of SSPC business set out in the SSPC's meeting agenda, that member must declare an interest at the start of the SSPC meeting. SSPC members should seek advice from the SSPC Chair, through the Head of Finance and Business Improvement before the start of the SSPC meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the SSPCs minutes.

7.2.3 It is the responsibility of the SSPC Chair, on behalf of the SSPC, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i the declaration is formally noted and recorded, but that the SSPC member should participate fully in the SSPC's discussion and decision, including voting.
ii the declaration is formally noted and recorded, and the SSPC member participates fully in the SSPC's discussion, but takes no part in the SSPC's decision;
iii the declaration is formally noted and recorded, and the SSPC member takes no part in the SSPC discussion or decision;
iv the declaration is formally noted and recorded, and the SSPC member is excluded for that part of the meeting when the matter is being discussed. A SSPC member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the SSPC.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a SSPC member is compatible with an identified conflict of interest.

7.2.5 Where the SSPC Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the SSPC.

7.2.6 In all cases the decision of the SSPC Chair (or the Vice Chair in the case of an interest declared by the Shared Services Committee Chair) is binding on all SSPC members. The SSPC Chair should take advice from the Head of Finance and Business Improvement when determining the action to take

in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a SSPC member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the SSPC including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The SSPC may determine that the SSPC member concerned shall be excluded from that part of the meeting.

7.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These Shared services SOs must be interpreted in accordance with these definitions.

1.0.5

7.2.9 **Members with Professional Interests –** During the conduct of a SSPC meeting, an individual SSPC member may establish a clear conflict of interest between their role as a SSPC member and that of their professional role outside of the SSPC. In any such circumstance, the SSPC shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Head of Finance and Business Improvement.

7.3 **Dealing with Officers' Interests**

7.3.1 The SSPC must ensure that the Head of Finance and Business Improvement, on behalf of the Managing Director of Shared Services, establishes and maintains a system for the declaration, recording and handling of Shared Services officers' interests in accordance with the Values and Standards of Behaviour Framework.

7.4 **Reviewing How Interests are Handled**

7.4.1 The SSPC's Audit Committee will review and report to the HBs, Trusts and Special Health Authority upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 **Dealing with Offers of Gifts[2] and Hospitality**

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other

[2] The term gift refers also to any reward or benefit

7.5.1 The Committee will adopt the Values and Standards of Behaviour Framework Policy of Velindre NHS Trust, which prohibits SSPC members and Shared Services officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any SSPC member or Shared Services officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a SSPC member or Shared Services officer. Compliance with the Velindre NHS Trust Values and Standards of Behaviour Framework is mandatory for all Trust employees.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Head of Finance and Business Improvement as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case, accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the SSPC;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, sporting, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the SSPC; and

- **Reputation:** If the body concerned is known to be under investigation by or

has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 **Register of Gifts and Hospitality**

7.6.1 The Head of Finance and Business Improvement, on behalf of the SSPC Chair, will maintain a Register of Gifts and Hospitality to record offers of gifts and hospitality made to SSPC members. Shared Services Director of Finance and Corporate Services together with Heads of Service, will adopt the Velindre University NHS Trust Policy on Gifts and Hospitality in relation to Shared Services officers working within their areas.

7.6.2 Every SSPC member and Shared Services officer has a personal responsibility to volunteer information in relation to offers of gifts and hospitality made in their capacity as SSPC members, including those offers that have been refused. The Head of Finance and Business Improvement, on behalf of the SSPC Chair and Managing Director of Shared Services, will ensure the incidence and patterns of offers and receipt of gifts and hospitality is kept under active review, taking appropriate action where necessary.

7.6.3 When determining what should be included in the register, Shared Services Officers must apply the principles as set out in the Velindre University NHS Trust Policy on gifts and hospitality.

7.6.4 SSPC members and Shared Services officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the SSPC;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.6.5 The Head of Finance and Business Improvement will arrange for a full report of all offers of Gifts and Hospitality recorded by the SSPC to be submitted to Velindre's Audit Committee at least annually. The Audit

Committee will then review and report to the SSPC and the Velindre Board upon the adequacy of the SSPCs arrangements for dealing with offers of gifts and hospitality.

7.6.6 Detailed arrangements for the handling of gifts and hospitality are set out within the Velindre University NHS Trust Values and Standards of Behaviour framework and its policy on Gifts and Hospitality.

8 SIGNING AND SEALING DOCUMENTS

The Common Seal of NWSSP's host is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

Where the Velindre Board has decided that a NWSSP document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised Independent Member) and the Chief Executive (or another authorised individual) both of whom witness the seal.

8.1 Register of Sealing

8.1.1 The Head of Finance and Business Improvement shall keep a register that records the sealing of every NWSSP document. Each entry must be signed by the person who approved and authorised the document and who witnessed the seal. A report of all sealing shall be presented to the SSPC at least biennially.

8.2 Signature of Documents

8.2.1 Where a signature is required for any document connected with legal proceedings involving the NWSSP, it shall normally be signed by the Managing Director, except where the SSPC has been otherwise directed to allow or require another person to provide a signature.

8.2.2 The Managing Director or nominated officers may be authorised by the SSPC to sign on behalf of the NWSSP any agreement or other document (not required to be executed as a deed) where the subject matter has been approved by the SSPC.

8.3 Custody of Seal

8.3.1 The Common Seal of NWSSP's host is kept securely by the Board Secretary.at Velindre University NHS Trust.

9 GAINING ASSURANCE ON THE CONDUCT OF SHARED SERVICES PARTNERSHIP COMMITTEE BUSINESS

The SSPC shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to Velindre on the conduct of SSPC business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

The SSPC shall ensure that its assurance arrangements are operating effectively, advised by Velindre's Audit Committee.

9.1 The role of Internal Audit in Providing Independent Internal assurance

9.1.1 The SSPC shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

9.1.2 The SSPC shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the SSPC. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Audit Committee facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the SSPC on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

9.2 Reviewing the performance of the Shared Services Partnership Committee, its sub- Committees, Expert Panel and Advisory Groups

9.2.1 The SSPC shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Sub-Committees, Expert Panel and any other Advisory Groups. Where appropriate, the SSPC may determine that such evaluation may be independently facilitated.

9.2.2 Each Sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the SSPC through the Chair within 1 month of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

9.2.3 The SSPC shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Committee Development Programme, as part of an overall Organisation Development framework; and
- inform its Partners through its annual report of its alignment with the Assembly Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

9.3 External Assurance

9.3.1 The SSPC shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on its operations, e.g. the Wales Audit Office and Healthcare Inspectorate Wales.

9.3.2 The SSPC may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the SSPC itself may commission specifically for that purpose.

9.3.3 The SSPC shall keep under review and ensure that, where appropriate, the SSPC implements any recommendations relevant to its business made by the National Assembly for Wales Commission Audit and Risk Assurance Committee, the Public Accounts Committee or other appropriate bodies.

9.3.4 The SSPC shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities under section 145 of and paragraph 17 to Annexe 8 to the Government of Wales Act 2006 (C.42).

10 DEMONSTRATING ACCOUNTABILITY

10.1.1 Taking account of the arrangements set out within these Shared Services SOs, the SSPC shall demonstrate to its Partners, citizens and other stakeholders and to Velindre, as host, a clear framework of accountability within which it:

- conducts its business internally;
- works collaboratively with NHS colleagues, Partners, service providers and others; and
- responds to the views and representations made by those who represent the interests of the citizens it serves and its own Shared Services officers.

10.1.2 The SSPC shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an annual report.

10.1.3 The SSPC shall also facilitate effective scrutiny of NWSSP's operations through the publication of regular reports on activity and performance, including publication of an Annual Review document providing a summary of annual performance.

10.1.4 The SSPC shall ensure that within the Shared Services staff, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

11 SUPPORT FOR THE SHARED SERVICES PARTNERSHIP COMMITTEE

11.1.1 The Head of Finance and Business Improvement, on behalf of the SSPC Chair, will ensure that the SSPC is properly equipped to carry out its role by:

- overseeing the process of nomination and appointment to the SSPC;
- co-ordinating and facilitating appropriate induction and organisational development activity;
- ensuring the provision of governance advice and support to the SSPC Chair on the conduct of its business and its relationship with its Partners, Velindre,

as the host and others;

- ensuring the provision of secretariat support for SSPC meetings;
- ensuring that the SSPC receives the information it needs on a timely basis;
- ensuring strong links to communities/groups;
- ensuring an effective relationship between the SSPC and Velindre as its host;
- facilitating effective reporting to each HB, Trust and Special Health Authority;

there by enabling each HB, Trust and Special Health Authority's Board to gain assurance on the conduct of business carried out by SSPC on their behalf.

12 REVIEW OF STANDING ORDERS

12.1.1 These Shared Services SOs shall be reviewed annually by the SSPC, which shall report any proposed amendments to the Velindre Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in Shared Services SOs, including the Equality Impact Assessment.

Annexe 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annexe forms part of, and shall have effect as if incorporated in the Shared Services Partnership Committee Standing Orders

MODEL SCHEME OF RESERVATION

AND DELEGATION OF POWERS

As set out in Standing Order 2, the SSPC - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the NWSSP may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The SSPC may delegate functions to:

i A Committee, e.g., Audit Committee;
ii A sub-Committee,
iii A joint-Committee or joint sub-Committee, e.g., with other HBs established to take forward matters relating to specialist services; and
iv Officers of NWSSP (who may, subject to the SSPC'S authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the SSPC is notified of any matters that may affect the operation and/or reputation of NWSSP.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Annexe of matters reserved to SSPC;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officer.

all of which form part of the SSPC's SOs

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE:

GUIDING PRINCIPLES

The SSPC will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the SSPC unless it is specificallydelegated in accordance with the requirements set out in SOs or SFIs
- The SSPC must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management
- Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility
- The SSPC must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development
- The SSPC must take appropriate action to assure itself that all matters delegated are effectively carried out
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes
- Except where explicitly set out, the SSPC retains the right to decide upon any matter for which it has responsibility, even if that matter has been delegated to others
- The SSPC may delegate authority to act, but retains overall responsibility and accountability
- When delegating powers, the SSPC will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Shared Services Partnership Committee (SSPC)

The SSPC will formally agree, review and, where appropriate revise Annexes of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Managing Director

The Managing Director will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The SSPC must formally agree this scheme.

In preparing the scheme of delegation to officers, the Managing Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive,
- NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Managing Director may re-assume any of the powers they have delegated to

others at any time.

Board Secretary Governance Support/ The Head of Finance and Business Improvement

The Board Secretary Governance Support/the Head of Finance and Business Improvement will support the SSPC in its handling of reservations and delegations by ensuring that:

- A proposed Annexe of matters reserved for decision by the SSPC is presented to the SSPC for its formal agreement;
- Effective arrangements are in place for the delegation of NWSSP's functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the SSPC, Audit Committee and Velindre Board for revision and approval, as appropriate.

The Velindre University NHS Trust Audit Committee for NWSSP

The Velindre University NHS Trust Audit Committee for NWSSP will provide assurance to the SSPC and Velindre University NHS Trust Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Velindre University NHS Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary providing Governance Support to the SSPC of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the SSPC has set out alternative arrangements.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within NWSSP. The Scheme is to be used in conjunction with the system of control and other established procedures within NWSSP.

SECTION 1

ANNEXE OF MATTERS RESERVED TO THE SSPC[3]

SSPC		AREA	DECISIONS RESERVED TO THE SSPC
1	FULL	GENERAL	The SSPC may determine any matter for which it has statutory or delegated authority, in accordance with NWSSP SOs
2	FULL	GENERAL	The SSPC must determine any matter that will be reserved to the whole SSPC in accordance with statutory and Welsh Government guidance.
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the SSPC, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: • NWSSP SOs ; • NWSSP SFIs; • Annexe of matters reserved to the SSPC;

[3] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements

			• Scheme of delegation to SSPC others; and • Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Approve the SSPC Values and Standards of Behaviour framework, including NWSSP's mission statement.
6	FULL	OPERATING ARRANGEMENTS	Approve the SSPC framework for performance management, risk and assurance
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the SSPC determines it so based upon its contribution/impact on the achievement of the SSPC's aims, objectives and priorities
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Managing Director in accordance with NWSSP Standing Order requirements
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with NWSSP SOs
10	FULL	OPERATING ARRANGEMENTS	Approve procedures for dealing with complaints and incidents.
11	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with NWSSP SFIs

12	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Managing Director and officers
13	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the NWSSP
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of the Management Team and any other SMT level appointments, e.g., the Committee Secretary
15	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of NWSSP members' interests, in accordance with advice received, e.g. From Audit Committee
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the NWSSP's top level organisation structure and SSPC policies
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss SSPC sub-Committees, including any joint sub-Committees directly accountable to the SSPC
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the SSPC
17	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the SSPC on outside bodies and groups

18	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the SSPC
19	FULL	STRATEGY & PLANNING	Determine the SSPCs strategic aims, objectives and priorities
20	FULL	STRATEGY & PLANNING	Approve the SSPCs Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
21	FULL	STRATEGY & PLANNING	Approve the SSPCs Risk Management Strategy, including risk appetite, risk tolerance levels and treatment plans and managing risks in relation to public confidence
22	FULL	STRATEGY & PLANNING	Approve the SSPCs citizen engagement and involvement strategy, including communication
23	FULL	STRATEGY & PLANNING	Approve the SSPCs Committee's partnership and stakeholder engagement and involvement strategies
24	FULL	STRATEGY & PLANNING	Approve NWSSP's key strategies and programmes related to: ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans) ▪ Primary Care ▪ Communications & Engagement

25	FULL	STRATEGY & PLANNING	Approve the SSPCs budget and financial framework (including overall distribution of year end surplus/deficits including risk sharing agreements
26	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Managing Director set out in the NWSSP SFIs
27	FULL	PERFORMANCE & ASSURANCE	Approve the SSPCs audit and assurance arrangements
28	FULL	PERFORMANCE & ASSURANCE	Receive reports from the SSPCs NWSSP Directors on progress and performance in the delivery of the SSPCs strategic aims, objectives and priorities and approve action required, including improvement plans
29	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the SSPCs sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
30	FULL	PERFORMANCE & ASSURANCE	Receive reports on the SSPC's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc) that raise issue or concerns impacting on the NWSSP's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of SSPC sub-Committees (as appropriate)

31	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the SSPCs Head of Internal Audit and approve action required, including improvement plans
32	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the SSPC's external auditor and approve action required, including improvement plans
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the SSPC's performance against the Health and Care Standards for Wales and approve action required, including improvement plans
34	FULL	PERFORMANCE & ASSURANCE	Approval of the Risk and Assurance Framework
35	FULL	REPORTING	Approve the SSPC's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government
36	FULL	REPORTING	Receive, approve and ensure the publication of SSPC reports, including its Annual Report

SECTION 2

ANNEXE OF DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Under Standing Order Section 2 it provides that the SSPC may delegate powers to SSPC Committees, Sub Committees and others. In doing so, the SSPC has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees;
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others;

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

Subject to Clauses within the Trust Standing Orders and to such directions as may be given by the Welsh Government, the SSPC may appoint ad hoc committees of the NWSSP whose membership can be wholly or partly of the Chairman and Directors of the NWSSP or persons who are not Directors of the NWSSP.

A committee appointed under this regulation may subject to such directions as may be given by the Welsh Government or the SSPC appoint ad hoc Sub-Committees consisting wholly or partly of members of the committee (whether or not they are Directors of NWSSP) or wholly of persons who are not members of the committee (whether or not they include Directors of the NWSSP).

The Standing Orders, with appropriate alterations, apply to a committee or Sub-Committee and to a committee or Sub-Committee as they apply to the SSPC and apply to a member of such committee or subcommittee (whether or not (s)he is a Director of the NWSSP) as it applies to a Director of the NWSSP.

The SSPC may make, vary and revoke Standing Orders relating to the quorum, proceedings and place of meetings of a committee or Sub-Committee but, this shall be carried out in accordance with the identified procedures laid down for these changes as outlined in these Standing Orders.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the SSPC's Scheme of Delegation to Committees.

The SSPC has delegated a range of its powers to the following sub-Committees and others:

- Welsh Risk Pool Committee
- Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Summary of matters delegated to Sub- Committees:

Sub-Committee: Welsh Risk Pool Committee **Delegated Matters:**
The Sub-Committee will: 1. To approve the payment and reimbursement of claims and impose penalties in accordance with the WRPS Claims Reimbursement Procedure. 2. To enact the risk sharing arrangements as agreed by the NWSSP. 3. To receive and consider the annual statements of account. 4. To receive and consider the annual assessment reports and to approve recommendations for any necessary action. 5. To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action. 6. To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately. 7. To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk. 8. To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All Wales basis. 9. To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.
Sub-Committee: Velindre University NHS Trust Audit Committee for NWSSP **Delegated Matters:**
The Committee will: 1. Approve any variation to, review annually and monitor compliance with Standing orders and Standing Financial Instructions. 2. Review and report to the SSPC upon the adequacy of the arrangements for declaring, registering and handling interests at least annually. 3. Receive a full report of all offers of Gifts and Hospitality recorded by the NWSSP and review the adequacy of NWSSP's arrangements for dealing with offers of gifts and hospitality. 4. Advise the Velindre Board on the adequacy that its assurance arrangements are operating effectively. 5. Review and approve Internal Audit Strategy, Charter, operational plan, programme of work. 6. Review effectiveness of internal audit. 7. Review policies and procedures in respect of fraud and bribery set out in the Welsh Government Directions and to receive the Counter Fraud Annual Report and Plan. 8. Approve write off of losses or making of special payments within delegated limits determined by the Welsh Ministers.

9. Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities.
10. Review the assurance gained through the development of a Risk and Assurance Framework and to consider gaps in control and gaps in assurance and report results to the Board.
11. Review the adequacy of all risk and control related disclosure statements, including the Annual Governance Statement.
12. Receive quarterly assurance of Post Payment Verification (PPV) reports.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the NWSSP's Scheme of Delegation to Committees.

SECTION 3

ANNEXE OF SCHEME OF DELEGATION TO NWSSP DIRECTORS AND OFFICERS

The SSPC SOs, alongside the Trust SOs and the SFIs specify certain key responsibilities of the Chief Executive Velindre University NHS Trust, the Managing Director of Shared Services, Directors, Heads of Service and other officers. The Chief Executive and Managing Director of Shared Services Job Descriptions, together with their Accountable Officer Memorandums set out their specific responsibilities, and the individual job descriptions determined for Directors and Heads of Service level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the Annexe of additional delegations below and the associated financial delegations set out in the Velindre Trust SFIs form the basis of the Scheme of Delegation to Officers.

Standing Orders – List of Delegated Matters

S.O Ref	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
GENERAL			
	Non Compliance and variation of standing orders Final interpretation of Standing Orders	Head of Finance and Business Improvement Chair	Board Secretary Support (Director of Corporate Service & Governance/Board Secretary Support Cwm Taf UHB)

	Responsibility for providing advice to the Board on all aspects of governance/committee services	Head of Finance and Business Improvement	
CHAIR'S ACTION ON URGENT MATTERS			
SO 2.1	Use of Chair's Action and onward reporting to	Chair & Managing Director	Board Secretary Support (Director of Corporate Service & Governance/Board Secretary Support Cwm Taf UHB
DELEGATION TO OFFICERS			
SO 2.3.1	Compilation of Scheme of Delegation for functions delegated to Managing Director for consideration and approval by the SSPC	Managing Director	Head of Finance and Business Improvement
SO 2.3.1	Delegation of functions within Directorates/departments/localities in line with the framework established by the Managing Director and agreed by the SSPC	Directors	Directors
WORKING IN PARTNERSHIP			
SO 5.0.2	Identification and engagement with all key partners and regular review of effectiveness	Chair	IMTP Lead

MEETINGS			
SO 6.2	Development of the Annual Plan of SSPC Business	Chair/Managing Director	Head of Finance and Business Improvement
SO 6.3	Call meetings of the SSPC	Chair/Managing Director	Head of Finance and Business Improvement
SO 6.4	Preparation of SSPC meetings	Chair/Managing Director	Head of Finance and Business Improvement
SO 6.5	Report decisions made & review NWSSP business conducted in private session	Chair	Head of Finance and Business Improvement
SO 6.5	Chair SSPC meetings & associated responsibilities	Chair	Chair (Vice Chair in Chair's absence) / Head of Finance and Business Improvement
SO 6.6	A record of proceedings of SSPC meetings	Chair (Vice Chair in Chair's absence)	
VALUES AND STANDARDS OF BEHAVIOUR			
SO 7.1	Establishment, maintenance and annual review of a Register of Interests declared by all SSPC members	Managing Director	Head of Finance and Business Improvement

SO 7.6	Establishment, maintenance and annual review of a Register of Gifts and Hospitality in respect of SSPC business for all SSPC members	Chair	Head of Finance and Business Improvement
SO 7.6	Establishment maintenance and annual review of a Register of Gifts and Hospitality for NWSSP Officers	Managing Director/Directors	Head of Finance and Business Improvement
SIGNING AND SEALING DOCUMENTS			
SO 8.1	Establishment, maintenance and bi-annual reporting of a Register of Sealings undertaken by the Velindre NHS Trust Board for NWSSP business	Managing Director	Head of Finance and Business Improvement

This scheme only relates to matters delegated by the Velindre Board and the SSPC to the Managing Director and Directors, together with certain other specific matters referred to in SFIs. Each Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annexe of Additional Delegations

Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Managing Director of Shared Services / NWSSP Director of Finance	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Trust Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Financial policies & procedures
Engagement of staff within funded establishment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Managing Director of Shared Services	Nominated deputy	In absence of Director of Shared Services
Staff re-grading and awarding of incremental points	NWSSP Director of W&OD	Yes	Written authority to suitably qualified HR staff
Approval of overtime	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures

Approval of compassionate leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of leave without pay	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Managing Director of Shared Services NWSSP Directors	 No Yes	 Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Managing Director NWSSP/ NWSSP Director of W&OD	No	
Approval of relocation costs	NWSSP Director of W&OD	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • NWSSP Directors • Other staff	Managing Director of Shared Services NWSSP Directors	 No No	
Approval of redundancy, early retirement and ill-health retirement	Managing Director of Shared Services	Yes	Authorisation matrix. HR policies & procedures

Dismissal of staff	Managing Director of Shared Services and NWSSP Director of W&OD	Yes	Authorisation matrix. HR policies & procedures
Approval to procure goods and services within budget	NWSSP Directors / Heads of Service	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Managing Director of Shared Services	Nominated deputy	In absence of the Director of Shared Services
Approval to commission services from other NHS bodies	Managing Director of Shared Services	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission services from voluntary sector	Managing Director of Shared Services	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission services from private and independent providers	Managing Director of Shared Services	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Managing Director of Shared Services	Yes	Authorisation matrix. Commissioning policies & procedures
Management and Control of Stocks	NWSSP Director (Head of Procurement Services)/ NWSSP DoF	Yes	Authorisation matrix
Work in relation to counter fraud and corruption	Trust Director of Finance/ NWSSP DoF	Yes	Authorisation matrix Fraud & Corruption policies and procedures

Authorisation of sponsorship	Managing Director of Shared Services	No	Sponsorship policies & procedures
Approval of research projects	Managing Director of Shared Services	Yes	Research policies & procedures
Management of complaints	NWSSP Director of Finance	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	NWSSP Directors / Trust Board Secretary	Yes	Communication policies & procedures
Approval for use of charitable funds	Trust Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose of equipment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation (except for personal effects)	Managing Director of Shared Services	No	Within authorised limits set by WAG.
Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	Trust Small Claims Panel Managing Director of Shared Services Approval by WAG	No No No No	
Approval of clinical negligence and personal injury claims	Trust Director of Nursing	Yes	Authorisation matrix and within limits set by WAG.

Approval of capital expenditure	Managing Director of Shared Services / NWSSP Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	NWSSP Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Managing Director of Shared Services	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Managing Director of Shared Service & NWSSP Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Heads of Service.

This scheme only relates to matters delegated by the SSPC to the Managing Director of Shared Services and the NWSSP Directors and Heads of Service, together with certain other specific matters referred to in SFIs. Each NWSSP Director and Head of Service is responsible for delegation within their department. They shall produce a Scheme of Delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

SECTION 4

ANNEXE OF DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Velindre University NHS Trust Standing Financial Instructions detail the requirements for Budgetary Control, including:

5.1 Budget Setting
5.2 Budgetary Delegation
5.3 Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Income and Expenditure budgetary responsibility for the NHS Wales Shared Services Partnership has been delegated to the Managing Director of Shared Services.

The Managing Director of Shared Services and other Shared Service Directors will, in turn, delegate budgetary responsibility to other Heads of Service and managers. The detailed Annexe of this second tier delegation will be reviewed, revised and reapproved on an annual basis by the Managing Director of Shared Services and the Senior Management Team as part of the annual Financial Strategy and Budget Setting process. Within the budgetary delegation there are delegated powers of budget virement:

- between Divisions must be approved by the Managing Director of Shared Services.
- between budgets within the same Division must be approved by the relevant Director / Heads of Service.
- between staff and non-staff within the same budget must be approved by the Budget Holder.

These delegated powers of virement, from the Managing Director of Shared Services to Heads of Service and Budget Holders, assume that the NWSSP is achieving its financial targets and can be revised, in year, by the Director of Shared Services in the light of adverse financial performance. Budget virements within Divisions can be authorised by the Head of Service and Director of Finance up to the limit of £60,000.

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF BUDGETARY DELEGATION

Financial Limits (All Values exclude VAT)	Revenue	Capital	Charitable Funds	Education & Training Contracts
	£000	£000	£000	£m
Velindre - Corporate Services:				
Trust Board	No Limit	No Limit	0	
Charitable Funds Committee	0	0	No Limit	
NWSSP (excluding all Wales Procurement Contracts):				
Managing Director/NWSSP Chairman	200	750*	0	
Managing Director of Shared Services	100	100	N/A	£5m
Director of Finance and Corporate Services	80	80	N/A	£2m
Director of Workforce and OD	50	50	N/A	N/A
Service Directors/Heads of Services (within own area)	25	0	N/A	N/A
Service Directors/Heads of Service's Nominee (within Agreed area)	10	10	N/A	N/A
Heads of Function (within own area)	7.5	7.5	N/A	N/A
Head of Financial Sustainability and Improvement	10	10	N/A	N/A
Head of Financial Management	10	10	N/A	N/A
Delegated Budget Holders (within own area) Level 1	5	0	N/A	N/A

Delegated Budget Holders (within own area) Level 2	1	0	N/A	N/A
Notes:				
***Along with approval of Shared Services Partnership Committee* Franking Machine and Secure Printing Contract within Primary Care Services has a higher limit for Service Directors/Head of Service this is 20k and for Head of Function it is £10k.				

Welsh Infected Blood Support Services Limits

Scheme Designation	Payments to Claimants
Managing Director/NWSSP Chairman	Over £100k
Managing Director	Up to £100k
Director of Finance and Corporate Services	Up to £80k
Head of Service	Up to £50k
Head of Function	Up to £10k

Corporate Areas

Scheme Designation	Area	Limits

Managing Director/Director of Finance and Corporate Services	ESR Recharges	Up to £750k
Managing Director/Director of Finance and Corporate Services	Intra-NHS Invoices and Payments (included but not limited to Pharmacy rebates, NWSSP distribution)	Up to £500k

Legal & Risks Services Limits

Scheme Designation	Reimbursement of claims following Advisory Board approval	WRP Managed Claims (Health Authority and Powys THB)
Managing Director of Shared Services/NWSSP Chairman	Over £2m	Over £2m
Managing Director of Shared Services	Up to £2m	Up to £2m
Director of Finance and Corporate Services	Up to £1m	Up to £1m
Director - Legal and Risk Services	Up to £500k	Up to £500k
Head of WRP Finance	Up to £100k	Up to £100k
WRP Claims Support		£20k
Note:		
All reimbursement claims are reviewed by the Advisory Board prior to approval and claims above £1m are reviewed by Welsh Government prior to the Advisory Board. Claims above £2m will also be signed by the Managing Director of Shared Services and NWSSP Chairman.		
Periodical Payments:		
Head of WRP Finance - authorises new periodical payment. Head of WRP Finance - authorises payment Annexes.		

Procurement Services Limits

Scheme Designation	*Contracts for and on behalf of NHS Wales	NWSSP Stock Requisitions and Invoices	** NWSSP Stock Write offs
Managing Director of Shared Services / NWSSP Chair (with Committee support)	Over £1m	Over £2m	Over £50k
Managing Director of Shared Services	Up to £1m	Up to £100k	Up to £50k
NWSSP Director of Finance and Corporate Services	Up to £750k	Up to £60k	Up to £25k
Director of Procurement Services	Up to £750k	Up to £50k	Up to £25k
Senior Manager Procurement Services (Logistics)		Up to £25k	Up to £10k
Regional Supply Chain Manager			Up to £5k
Warehouse Manager (Bridgend/Denbigh) / Storage and Distribution Manager (Cwmbran)			Up to £1k
Assistant Warehouse Manager (Bridgend/Denbigh) / Shift Manager (Cwmbran)			Up to £1k

Annexe 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annexe forms part of, and shall have effect as if incorporated in the Shared Services Partnership Committee Standing Orders

Shared Services Partnership Committee Framework

The SSPC's governance and accountability framework comprises these Shared Services SOs, incorporating Annexes of Powers reserved for the SSPC and Delegation to others, together with the following documents agreed by the SSPC.

These documents must be read in conjunction with the Shared Services SOs and will have the same effect as if the details within them were incorporated within the Shared Services SOs themselves.

- Standing Financial Instructions (SFIs)
- Values and Standards of Behaviour Framework
- Risk and Assurance Framework
- SSPC Annual Plan of Committee Business
- Welsh Language Scheme
- Complaints Management Protocol
- Annual Governance Statement
- Annual Review

These documents may be accessed by viewing NWSSP's website (www.nwssp.wales.nhs.uk/opendoc/326169).

NHS Wales Framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at http://www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of SSPC business are also issued in hard copy, usually under cover of a Ministerial Letter.

Annexe 3

SHARED SERVICES PARTNERSHIP COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. *Welsh Risk Pool Committee - Terms of Reference*

2. *Velindre University NHS Trust Audit Committee For NHS Wales Shared Service Partnership - Terms of Reference*

1. Welsh Risk Pool Committee
Terms of Reference

1. Background

1.01 NHS Wales Shared Service Partnership (NWSSP) has responsibility for the administration of the Welsh Risk Pool Service including the management of the Welsh Risk Pool Budget.

1.02 The aim of the WRPS budget management is to align the financial governance relating to claims and Redress cases with the corporate and quality governance agenda.

1.03 The Welsh Risk Pool Services has responsibility for reimbursement of claims over £25,000 and reimbursement of permitted costs and damages arising from Redress cases. It is also required to have effective processes for ensuring that NHS Wales learns from events to limit the risk of recurrence and improve the quality and safety for both patients and staff.

1.04 In line with standing orders the Committee has resolved to establish a sub-committee to be known as the Welsh Risk Pool Committee (WRPC). The WRPC is a sub-committee of the NWSSP Committee and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Membership

2.01 The membership of the WRPC shall be determined by the NWSSPC, taking account of the balance of skills and expertise necessary to deliver the WRPC's remit and subject to any specific requirements or directions made by the Welsh Government.

2.02 The WRPC comprises of representation from senior NHS professionals from Trusts, Local Health Boards, Legal & Risk Services and the Welsh Government. The membership includes:

Chairman: Chairman of NWSSP

Members: Managing Director, NWSSP

Director Legal & Risk Services NWSSP

Director of Finance & Corporate Services NWSSP

Health Board or Trust Chair (1)

Health Board or Trust Chief Executive (1)

Health Board or Trust Medical Director (1)

Health Board or Trust Director of Nursing (1)

Health Board or Trust Director of Finance (1)

Health Board Director of Therapies & Health Science (1)

Health Board or Trust Chair Audit Committee Chair (1)

Health Board or Trust Board Secretary (1)

Welsh Government (2)

In attendance:

NWSSP – WRPS Head of Finance

NWSSP - WRPS Head of Safety and Learning

WRPS Operations Team

WRPS Safety and Learning Team

2.03 Other individuals may be involved at the discretion of the Chairman (e.g. representatives from NSAGs as appropriate). The WRPC shall appoint a vice chairman from the agreed membership. The vice-chair shall deputise for the Chair in their absence for any reason.

2.04 In the event that a member of the WRPC is unable to attend a meeting he/she is required to seek a suitable person to attend on their behalf.

3. Dealing with Members' interests during meetings

3.01 The Chair, advised by the Committee Secretariat, must ensure that the WRPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual members must

demonstrate, through their actions, that their contribution to the WRPC's decision making is based upon the best interests of the NHS in Wales.

3.02 Where individual members identify an interest in relation to any aspect of business set out in the meeting agenda, that member must declare an interest at the start of the meeting. Members should seek advice from the Chair, through the Committee Secretariat before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the minutes. It is responsibility of the chair, on behalf of the Committee, to determine the action to be taken in response to the declaration of interest, this can include excluding the member, where they have a direct or indirect financial interest or participating fully in the discussion but taking no part in the WRPC decision.

4. Quorum

4.01 A quorum shall be the Chairman or Vice Chair and at least 4 other representatives, 2 of which must be officer members of shared services and 2 of which must be NHS Trust or LHB representatives.

Repeated non-attendance will be reported to the NWSSP Committee.

5. Frequency of Meetings

5.01 Meetings will be held at least 8 times per year, with additional meetings held if considered necessary.

6. Authority

6.01 The Accountable Officer for NWSSP is authorised to carry out any activity within the terms of reference and the scheme of delegation. In the normal course of WRPC business items included on the agenda are subject to discussion and decisions based on consensus. Decisions made by the Accountable Officer against that recommended by the WRPC will be reported to the NWSSP Committee and the Velindre NHS Trust Audit Committee for Shared Services.

6.02 The WRPC may, establish sub groups or task and finish groups as appropriate to address specific issues and to carry out on its behalf specific aspects of business.

7. Responsibilities of the WRPC

7.01 It is important that there is clarity between the role of the WRPC and that of the NWSSP Committee. The NWSSP Committee will have overall responsibility for overseeing the governance arrangements within WRPS and in support of this function the minutes of the WRPC will be forwarded for information and assurance including the highlighting of matters of significance.

7.02 The role of the WRPC is to:

a. Receive assurance on the management of delegations for areas of responsibility detailed within this Terms of Reference and to report regularly to the Shared Services Partnership Committee on performance;
b. Undertake actions reserved specifically for the WRPC;
c. To provide advice and guidance to the NWSSP Accountable Officer on claims reimbursement decisions; and
d. To support and promote a learning culture within NHS Wales.

8. WRPS areas of responsibility

8.01 The main areas of responsibility for which WRPS will be held to account by the WRPC are:

- To present key financial and performance information.
- To develop an effective and efficient process including technical notes for the receipt of claims and reimbursement of monies to NHS Wales.
- To ensure that there are effective processes for the forecasting of resource requirements over the short and medium term and that there is sufficient liquidity to meet obligations.
- To ensure that the transactions of the WRPS are fully recorded and that financial accounts are produced in accordance with the timetable set by the Welsh Government.
- To undertake regular assessments of the arrangements for the management of Concerns and Claims by NHS Wales.
- To undertake the assessments of high risk clinical areas as required by Chief Executives of NHS Wales Bodies.
- To develop processes for learning from events and cascading information to all NHS Wales Bodies including undertaking detailed reviews of claims and identifying trends arising from claims.
- To undertake project work as required by the WRPC.
- To develop a process for the scrutiny of claims and Redress cases presented to each WRPC to provide assurance across NHS Wales that

appropriate action has been taken to reduce the risk of recurrence. This process should have regard for the number and complexity of claims being presented to ensure that sufficient consideration is given to issues arising.

- To develop an effective and efficient process for handling and responding to enquiries in relation to indemnity and reimbursement matters.

9. WRPC reserved matters

- To approve the reimbursement of claims and Redress cases and impose penalties in accordance with the Reimbursement Procedures.
- To enact the risk sharing arrangements as agreed by the NWSSP.
- To receive and consider the annual statements of account.
- To receive and consider the annual assessment reports and to approve recommendations for any necessary action.
- To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action.
- To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately.
- To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk.
- To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All Wales basis.
- To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.

10. Support and promote a learning culture across NHS Wales

10.1 The members of the WRPC will have collective responsibility for ensuring that the learning from events is formally considered and that a culture of improvement across NHS Wales is fostered. This will include providing advice and guidance at each meeting and where necessary taking action to address weaknesses identified, either at an individual organisational level or at a more strategic level.

11. Reporting Arrangements

11.01 Minutes shall be taken at each meeting and circulated to all members of the WRPC and to the NWSSP Committee for information.

11.02 Risk sharing arrangements will be agreed by the NWSSP Committee.

11.03 Regular financial reports on the risk sharing forecasting will be considered by the Shared Services Committee and provide to Welsh Government as and when required.

11.04 Annual presentations will be made to the groups identified by the WRPC (e.g. Chief Executives, Directors of Finance, Directors of Nursing and Medical Directors).

12. Audit Arrangements

12.01 The WRPS will be subject to audit by both internal and external auditors. The external auditors of Velindre NHS Trust will ensure that there is overall audit coverage of claims management across the NHS in Wales.

13. Associated documents

- All Wales Policy on Indemnity and Insurance
- Scope of the Risk Pooling Arrangements
- WRPS Reimbursement Procedures

2. Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership - Terms of Reference

1. BACKGROUND

1.1 In May 2012, all Health Boards and Trusts approved the Standing Orders for Shared Services Partnership Committee. Section 4.0.3 of the Standing Orders states:

*"The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or **utilise Velindre's Committee arrangements** to assist in discharging its governance responsibilities."*

These Terms of Reference set out the arrangements for utilising the Velindre University NHS Trust Audit Committee to support the discharge of those relevant functions in relation to NHS Wales Shared Services Partnership (NWSSP).

ORGANISATIONAL STRUCTURE

Velindre University NHS Trust has an interest in NWSSP on two levels:

a) The internal governance of NWSSP in relation to the host relationship; and
b) As a member of NWSSP Committee in relation to the running of national systems and services.

In 2012, it was agreed that the Velindre Audit Committee would be utilised to act on behalf of NWSSP Committee, that there would be a clear distinction between these two areas/functions and that they would be addressed separately under the Audit Committee arrangements. This 'functional split' allows for clear consideration of the issues relating specifically to the business of the nationally run systems and national services that are provided by NWSSP and avoids the boundaries between the governance considerations of the hosting relationship and the governance considerations of NWSSP being blurred. The functional split can be illustrated below:

(a) Governance (Host Relationship)	(b) Nationally Run Systems & Services
1 Velindre University NHS Trust 2 Audit Committee	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

The governance and issues relating to the hosting of NWSSP dealt with in **(a)** will be incorporated into the standard business of the existing Velindre University NHS Trust Audit Committee, with a specific focus on alternating Trust Audit Committee business. The assurance for the business dealt with in **(a)** will be to the Velindre University NHS Trust Board. The Chair of NWSSP Audit Committee should receive copies of the meeting papers and will be invited to attend if there is anything on the agenda which has implications for the Shared Services Partnership Committee (SSPC).

Issues relating to NWSSP nationally run systems and services **(b)** will be fed into a separate Velindre University NHS Trust Audit Committee for NWSSP operating within its own work cycle. The assurance for the business dealt with in **(b)** will be to NWSSP Chair and the NWSSP Audit Committee, via the communication routes, detailed below.

The arrangements for **(a)** above, will not be considered further within these Terms of Reference, as it is for Velindre University NHS Trust Audit Committee to determine the relevant assurance required in relation to the host relationship.

This document goes on to outline the Terms of Reference for **(b)**, above.

2. INTRODUCTION

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

2.2 In line with Standing Orders and NWSSP's scheme of delegation, the SSPC shall nominate, annually, a Committee to be known as the Velindre University NHS Trust Audit Committee for NWSSP. The detailed Terms of Reference and Operating Arrangements in respect of this Committee are set out below.

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

3 PURPOSE

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

- ***Advise*** and ***assure*** the SSPC and the Accountable Officer on

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

Where appropriate, the Committee will advise the Velindre University NHS Trust Board and SSPC as to where and how its system of assurance may be strengthened and developed further.

4 DELEGATED POWERS AND AUTHORITY

4.1 With regard to its role in providing advice to both Velindre University NHS Trust Board and the SSPC, the Audit Committee will comment specifically upon:

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

  - NWSSP's ability to achieve its objectives;
  - Compliance with relevant regulatory requirements, standards, quality and service delivery requirements, other directions and requirements set by the Welsh Government and others;
  - The reliability, integrity, safety and security of the information collected and used by the organisation;
  - The efficiency, effectiveness and economic use of resources; and
  - The extent to which NWSSP safeguards and protects all of its assets, including its people.

- NWSSP's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- The planned activity and results of Internal Audit, External Audit and the Local Counter Fraud Specialist (including Strategies, Annual Work Plans and Annual Reports);
- The adequacy of executive and management's response to issues identified by audit, inspection and other assurance activity, via monitoring of NWSSP's Audit Action Plan;

- Proposals for accessing Internal Audit service (where appropriate);
- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the SSPC or the Accountable Officer may seek advice.

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

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit Statement, External Audit Opinion or other appropriate independent assurances), prior to endorsement by the SSPC;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by NHS Protect.

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

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

- The ***comprehensiveness*** of assurances in meeting the SSPC and the Accountable Officer's assurance needs across the whole of the organisation's activities; and
- The ***reliability and integrity*** of these assurances.

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

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There is an effective Counter Fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the SSPC and the Accountable Officer or through the effective completion of Audit Recommendations and the Audit Committee's review of the development and drafting of the Annual Governance Statement;
- The work carried out by key sources of external assurance, in particular, but not limited to the SSPC's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- The work carried out by the whole range of external review bodies is brought to the attention of the SSPC and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, together with the risks of failing to comply;
- The systems for financial reporting to the SSPC, including those of budgetary control, are effective; and
- The results of audit and assurance work specific to the organisation and the implications of the findings of wider audit and assurance activity relevant to the SSPC's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Audit Committee will follow and implement the Audit Committee for Shared Services Annual Work Plan and will be evidenced through meeting papers, formal minutes, and highlight reports to the SSPC, Velindre University Trust Board and annually, via the Annual Governance Statement, to the Velindre University NHS Trust's Chief Executive.

Authority

4.6 The Audit Committee is authorised by the SSPC to investigate or to have investigated any activity within its Terms of Reference. In doing so, the Audit Committee shall have the right to inspect any books, records or documents of NWSSP, relevant to the Audit Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

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

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

Access

4.8 The Head of Internal Audit and the Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee at any time and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

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

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

Sub Committees

4.11 The Audit Committee may, subject to the approval of the SSPC, establish Sub Committees or Task and Finish Groups to carry out on its behalf specific aspects of Committee business. Currently, there is an established Welsh Risk Pool Committee which is a Sub Committee of the SSPC, however, there are no Sub Committees of the Audit Committee.

5 MEMBERSHIP

Members

5.1 A minimum of 3 members, comprising:

Chair	Independent member of the Board

Members	Two other independent members of the Velindre University NHS Trust Board.
	The Audit Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.
	The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

5.2 In attendance:

NWSSP Managing Director, as Accountable Officer

NWSSP Chair

NWSSP Director of Finance & Corporate Services

NWSSP Director of Audit & Assurance

NWSSP Head of Internal Audit

NWSSP Audit Manager

NWSSP Head of Finance and Business Development

NWSSP Compliance Officer

Representative of Velindre University NHS Trust

Local Counter Fraud Specialist

Representative of the Auditor General for Wales

Other Executive Directors will attend as required by the Committee Chair

By invitation the Committee Chair may invite:

- any other Partnership officials; and/or

- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

The Velindre Chief Executive Officer should be invited to attend, where appropriate, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Secretariat

Secretary	As determined by the Accountable Officer

Member Appointments

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

5.4 Members shall be appointed to hold office for a period of four years. Members may be re-appointed, up to a maximum of their term of office. During this time a member may resign or be removed by the Velindre University NHS Trust Board.

5.5 Audit Committee members' Terms and Conditions of Appointment, (including any remuneration and reimbursement) are determined on appointment by the Minister for Health and Social Services.

Support to Audit Committee Members

5.6 The NWSSP Head of Finance and Business Development and NWSSP Compliance Officer, on behalf of the Audit Committee Chair, shall:

- Arrange the provision of advice and support to Audit Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Audit Committee members as part of the Trust's overall OD programme developed by the Velindre Executive Director of Workforce & Organisational Development.

6 AUDIT COMMITTEE MEETINGS

Quorum

6.1 At least two members must be present to ensure the quorum of the Audit Committee, one of whom should be the Audit Committee Chair or Vice Chair.

Frequency of Meetings

6.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Audit Committee deems necessary, consistent with NWSSP's Annual Plan of Business. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Withdrawal of Individuals in Attendance

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

7 RELATIONSHIP & ACCOUNTABILITIES WITH THE TRUST BOARD & SSPC DELEGATED TO THE AUDIT COMMITTEE

7.1 Although the Velindre University NHS Trust Board, with the SSPC and its Sub Committees, including the Welsh Risk Pool Sub Committee, has delegated authority to the Audit Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Audit Committee is directly accountable to the Velindre University NHS Trust Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Audit Committee, through its Chair and members, shall work closely with NWSSP and its other Sub Committees to provide advice and assurance to the SSPC by taking into account:

- Joint planning and co-ordination of the SSPC business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into NWSSP's overall risk and assurance arrangements. This will primarily be achieved through the discussions held at the SSPC, annually, at the end of the financial year.

7.1 The Audit Committee will consider the assurance provided through the work of the SSPC's other Committees and Sub Committees to meet its responsibilities for advising the SSPC on the adequacy of the organisation's overall system of assurance by receipt of their annual workplans.

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

8 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Audit Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board, SSPC and the Accountable Officer on the Audit Committee's activities. This includes verbal updates on activity and the submission of committee minutes, and written highlight reports throughout the year;
- Bring to the Velindre University NHS Trust Board, SSPC and the Accountable Officer's specific attention any significant matters under consideration by the Audit Committee; and
- Ensure appropriate escalation arrangements are in place to alert the SSPC Chair, Managing Director (and Accountable Officer) or Chairs of other relevant Committees, of any urgent/critical matters that may affect the operation and/or reputation of the organisation.

8.2 The Audit Committee shall provide a written Annual Report to the SSPC and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance

arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self assessment activity against relevant standards. The report will also record the results of the Audit Committee's self assessment and evaluation.

8.3 The Velindre University NHS Trust Board and SSPC may also require the Audit Committee Chair to report upon the Audit Committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g. where the Audit Committee's assurance role relates to a joint or shared responsibility.

8.4 The NWSSP Head of Finance and Business Development and NWSSP Compliance Officer, on behalf of the Partnership, shall oversee a process of regular and rigorous self-assessment and evaluation of the Audit Committee's performance and operation, including that of any Sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

9 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *(as per section on Committee meetings)*
- Notice of meetings
- Notifying the public of meetings
- Admission of the public, the press and other observers

10 REVIEW

10.1 These Terms of Reference and operating arrangements shall be reviewed annually by the Audit Committee with reference to the SSPC and Velindre University NHS Trust Board.

Annexe 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

1. Evidence Based Procurement Board (EBPB)

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. Terms of Reference of the Evidence Based Procurement Board (EBPB) of the NHS Wales Shared Services Partnership (NWSSP)

1. Aims and Objectives

The Board shall be known as the 'Evidence Based Procurement Board' (EBPB), and will consist of professionals from across various disciplines within NHS Wales and appropriate research bodies, making recommendations and guidance for implementation by the Welsh NHS**.**

The EBPB advises, promotes, develops and implements value and evidence based procurement of medical technologies for NHS Wales. The group will assist with rationalisation and standardisation in line with Prudent healthcare principles, underpinned with the "*Once for Wales*" philosophy, and will assess whether NHS Wales should discard devices/technologies if they are deemed inappropriate or wasteful.

The EBPB will produce advice and guidance to support planning and decision making in Local Health Boards and Trusts.

The EBPB shall provide advice, guidance and recommendations to the Shared Services Committee and the WG Efficiency Healthcare Value & Improvement Group.

The EBPB will support NHS Wales core values through the assessment of quality and safety elements of medical technologies; using this to provide high value evidence based care whilst reducing harm. In addition, through the rationalisation and standardisation programme, the EBPB will enable reduced variation and waste. It also specifically supports the 2018 report "*A Healthier Wales: our Plan for Health and Social Care*" principles of "Higher value" (better outcomes, better experience at reduced cost, less variation and no harm) and "Evidence driven" (the use of research, knowledge and information to understand what works).

In line with the emphasis of "Value" in "*A Healthier Wales*", the EBPB will play a key role in assisting the delivery of the Value Based Health Care agenda across the NHS in Wales.

It is acknowledged that there will be some areas that will be of mutual interest to Health Technology Wales (HTW) and these will be addressed through discussion with appropriate representatives.

2. MEMBERSHIP

Membership will be endorsed by Welsh Government and made up of senior professionals from NHS Wales and academia. The EBPB will consist of both voting and non-voting members. Membership is as follows;

- Chair - Medical Director/Assistant MD - Stephen Edwards
- NWSSP Director (SRO) - Mark Roscrow
- Finance Director - Hywel Jones
- Health Economist - Pippa Anderson
- Director of SMTL - Pete Phillips
- Health Technology Wales - Susan Myles
- Procurement Services - Andy Smallwood
- Deputy Executive Nurse Director - Jason Roberts
- Secondary Care Clinician - Paul Morgan
- National Clinical Lead for Prudent & Value Based Care/Primary Care Senior Clinician - Dr Sally Lewis
- Value Based Care/National Lead VBP - Adele Cahill
- Academic Clinician - Prof Haray
- Academia - Sam Evans
- NWSSP MD - Neil Frow

Non-voting members may be invited to attend as and when appropriate;

- Individuals co-opted for advice on specialist category areas, including Clinical networks and clinicians locally.
- Nominated experts from Evidence Research Group

Secretariat

- NHS Wales Shared Services Partnership – Procurement Services
- NHS Wales staff may request to attend as observers by writing in advance to the Chair.

Deputies

In the event of a voting member not being in attendance, an agreed named deputy should attend. The EBPB will approve deputies for all voting members of the group, (Chair excluded). A Vice Chair will be appointed in accordance with *Point 4.*

3. OFFICERS

The Chair will normally be a Medical Director/ Assistant Medical Director, appointed by the EBPB and approved by Welsh Government whose term of office shall normally be between 1-5 years. They will be eligible for re-appointment for an additional term of office, but the total period cannot exceed 10 years.

A Vice-Chair will be elected from the voting members. The Vice Chair or in their absence, another voting member may preside over meetings in the absence of the Chair.

4. MEETINGS

The EBPB will meet a minimum of 4 times per year, and roles and responsibilities of members should be readily available to any relevant party on request.

5. DECLARATION OF INTEREST

Members MUST declare, in advance any financial and/or personal interests, to any related matter that is subject of consideration. Any declarations made and/or actions taken will be noted in the minutes.

6. VOTING

Any issues/questions should be resolved by consensus. Only voting members will have voting rights. Deputies will be eligible to vote. The Chair will not normally vote on matters however in the case of equality of votes, the Chair or person presiding as Chair will have the casting vote. Members with a conflict of interest in a specific Topic, including members who have had a significant role in the preparation of the submissions being considered, will not cast a vote for that Topic.

7. QUORUM

Quorum will be 50% of voting members.

8. VALIDITY OF PROCEEDINGS/MEMBERSHIP VACANCIES

Validity of proceedings of the EBPB is not affected by a vacancy or defect in the appointment of a member of deputy. Membership of the EBPB shall end if;

- Members resign by giving notice in writing to the Chair of the EBPB
- Absenteeism from 3 consecutive ordinary meetings; unless the EBPB is satisfied that absence is due to reasonable cause
- Ceases to belong to the body they represent
- Term of office expires

9. EVIDENCE REVIEW GROUP (ERG)

The ERG is a standing committee which reports to the EBPB. Staff from SMTL and ProcS form the core membership who will undertake the day to day workload for the ERG.

The ERG will also include experts in Health Economics and Human Factors from Swansea University as and when required.

The ERG will liaise with other researchers and analysts as and when required, including partnering with HTW staff.

Expert Membership - The ERG will recruit expert members as and when required to provide clinical and domain-specific advice and expertise. Expert members may include Clinical experts from NHS Wales and Welsh Government National Special Advisory Groups (NSAGs).

10. POWERS OF THE EBPB

- The EBPB may require the Evidence Review Group (ERG) to convene meetings of expert advisors.
- The work and meetings of the ERG and expert advisors should be reported to the EBPB.
- The ERG should operate in an advisory role to the EBPB.
- The EBPB may seek independent advice as and when appropriate.
- The EBPB may commission external bodies to evaluate evidence in relation to products.
- The EBPB and ERG will incur the minimum necessary expenditure to enable their work to be carried out. These expenses will be considered and administered by NWSSP Shared Services Procurement Services.
- Nominated experts from the ERG may be required to attend meetings of the EBPB.

11. GOVERNANCE AND ACCOUNTABILITY

The EBPB is accountable to the NWSSP committee and will utilise NWSSP's governance structures.

12. ROLES AND RESPONSIBILITIES

- Support the rationalisation and standardisation agenda in line with prudent Healthcare principles.
- Review evaluations and evidence assessments of medical technologies.
- Develop a work programme determined by Health Boards/Trusts, Welsh Risk Pool and other stakeholders.
- Provide advice to stakeholders regarding new or innovative products for use across NHS Wales in consultation with HTW.
- Liaise with Academia on the EBPB work programme, including product development initiatives where appropriate.
- Participate in horizon scanning with other agencies such as HTW and advise on the potential impact for the NHS.
- Provide advice on clinical pathways/treatments where devices and consumables are part of the clinical process, complimenting and supporting the work of NICE.
- Receive for consideration into the work programme topics referred by WG and other key stakeholders. This will include liaison with HTW's Front Door Group.

- Liaise and engage with professional peers.
- Produce an Annual report for review by NHS Wales and Shared Services Partnership Committee.
- Consider NICE guidance and Do Not Do recommendations when developing the work programme.
- Develop mechanisms to audit adoption of the EBPB advice.

13. GROUP STRUCTURE & METHODS

A separate document is available detailing the structure and working methodology of the EBPB and other structures.

Annexe 5

Process for the Selection, Appointment and Termination of the Chair of the SSPC

This Annexe forms part of, and shall have effect as if incorporated in the Shared Services Committee Standing Orders

The NWSSP Committee has the responsibility for appointing the Chair of the Committee. Whist the appointment is not a Ministerial appointment the planned process will take account of the appointment principles outlined in the "Governance Code on Public Appointments" which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments.

MAIN BODY

In line with the Governance Code on Public Appointments to Public Bodies 2016 the principles of public appointments are summarised below:

A. **Ministerial responsibility** - The ultimate responsibility for appointments and thus the selection of those appointed rests with Ministers who are accountable to Parliament for their decisions and actions. Welsh Ministers are accountable to Welsh Government.

B. **Selflessness** - Ministers when making appointments should act solely in terms of the public interest.

C. **Integrity** - Ministers when making appointments must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

D. **Merit** - All public appointments should be governed by the principle of appointment on merit. This means providing Ministers with a choice of high quality candidates,

drawn from a strong, diverse field, whose skills, experiences and qualities have been judged to meet the needs of the public body or statutory office in question.

E. **Openness** - Processes for making public appointments should be open and transparent.

F. **Diversity** - Public appointments should reflect the diversity of the society in which we live and appointments should be made taking account of the need to appoint boards which include a balance of skills and backgrounds.

The essential features of the process will include the following:

- A panel must be set up to oversee the appointments process.
- The panel must be chaired by an independent assessor
- An agreed selection process, selection criteria and publicity strategy for a successful appointment
- A panel report must be prepared, signed by the chair of the appointment panel
- The appointment of the successful candidate must be publicised.

It is important that all public appointees uphold the standards of conduct set out in the Committee on Standards in Public Life's Seven Principles of Public Life. The panel must satisfy itself that all candidates for appointment can meet these standards and have no conflicts of interest that would call into question their ability to perform the role.

The selection panel will comprise of the following members:

- 3 members of the NWSSP Committee
- NWSSP Director of Workforce and OD

The appointment process is managed by the NWSSP Director of Workforce and OD.

A suite of supporting documentation has been developed to support the process.

The job **advertisement.** It is proposed that, in line with the practice adopted by Welsh Government for all other public appoints this post is advertised on Job Wales which is the Western Mail and Daily Post on-line publication.

The candidate application **form**. The content and format very closely mirrors the application form currently used by the Welsh Government for Ministerial Public Appointments.

A **briefing pack** for candidates. This includes details of the role profile and person specification.

Governance and Risk Issues

Whist the appointment is not a Ministerial appointment the planned process will take account of the appointment principles outlined in the "Governance Code on Public Appointments" which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments.

The appointment documentation and processes has been reviewed and agreed by the Director of Governance & Corporate Services/Board Secretary at Cwm Taff UHB who is a member of the SSPC; and has also been provided to the Director of Corporate Governance/Board Secretary at Velindre University NHS Trust to ensure that the appointment aligns to Velindre's governance requirements.

The selection process will be repeated following each maximum term of office for the Chair of the Committee, or when the Chair resigns, or following removal of the Chair by termination.

Suspension and Termination

Should the circumstances laid down in the draft regulations at 9. (1), 9.(3), 9.(5) or 10.(1) emerge, and the removal (i.e. suspension or termination) of the Chair is deemed necessary, the Committee will agree the reasons for the decision to do so and formally submit these reasons to a panel constituted as that described for the selection process above.

The panel will then make a recommendation to Velindre University NHS Trust to suspend or remove the Chair. Velindre University NHS Trust will then take the necessary action and subsequently provide the Welsh Ministers with the reasons agreed as per section 9.(2) (termination) or 10.(2) (suspension) of the Regulations.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Audit Committee

PROCUREMENT COMPLIANCE REPORT
June 2023 – September 2023
(Reporting Period)

DATE OF MEETING	19/10/2023
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	Matthew Bunce, Executive 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 24th June 2023 – 31st August 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 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 Run noted the assurance in relation to procurement activity undertaken during the period 24th June 2023 – 31st August 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.	02/10/2023
	(DD/MM/YYYY)
	(DD/MM/YYYY)
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	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 24th June 2023 – 31st August 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	1
11.13	Single Quotation Application or Single Tender Application	Single Tender Actions	0
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	3
10.4	Departures from SFIs	Award of additional funding outside the terms of the contract (File notes & Exemptions)	10

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Compliance Assurance (Appendix 1.1)

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

	VCC & Corporate	WBS	Total	Repeat Submission
SQA's	0	1	1	0
STA's	0	0	0	0
Total	**0**	**1**	**1**	**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 / Exemptions (Appendix 1.2 & 1.3)

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.

A summary of the Non-Compliant Activity / Contract Breach Summary is provide in the Table below. It details all Departments that have been reported for non-compliant breaches and exemptions in this period alongside their previous statistics for comparative purposes.

Year		**July'23**		**August '23**	
Division / Department	**Executive / Director Responsible**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**
Corporate					
Nursing	Nicola Williams	1			
Finance	Matthew Bunce	1			
Corporate Governance	Lauren Fear	1			1
RD&I					
Research & Development	Jaz Abrahams			1	

Year		July'23		August '23	
Division / Department	**Executive / Director Responsible**	**Non-Compliant Breaches**	**Exemption**	**Non-Compliant Breaches**	**Exemption**
nVCC					
nVCC Project	David Powell	2		1	
VCS					
Therapies	Rachel Hennessy	2			
Outpatients					
Operational Services					
Utilities					
VCC Planning					
Private Patients					
Medical Physics					
Service Improvement					
Radiation Protection					
Radiotherapy					
Radiology					
Nuclear Medicine					
Pharmacy					
WBS					
Corporate Services	Alan Prosser		1		
TOTALS		**6**	**1**	**2**	**1**

All Wales Contracts (Appendix 1.4)

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

2.2 **General Observations Update**

The Procurement department has undertaken a review of the SQA and STA requests that were submitted and approved from 24th June 2023 – 31st August 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)

No SQA's were submitted/approved for this period.

WBS (SQA's)

One SQA was submitted & approved for this period.

Single Tender Action (STA) Requests

No STA's were submitted/considered 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.

2.2 Other Matters of Interest

Trust Board Approvals Process – Update

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

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
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	**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	Yes - please Include further detail below, including funding stream As indicated in Appendices 1.1 (Summary Information of Compliant Arrangements) and 1.2 (Further Matters / Non-Compliant Arrangements) and 1.3 All Wales Contracts **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	Not required - please outline why this is not required

For more information: *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	*Not applicable*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Any procurement process could be subject to legal challenge where procurement regulations have not been complied with

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 24th June – 31st August 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)
Alan Prosser	WBS	Q.0006/WBS	08/06/23	Quotation	HLA SSO Kits	IBG Immucor	£3,963.22	One-off Purchase	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS	Q.0007/WBS	09/06/23	Quotation	Linkseq HPA Typing Kits	VH Bio	£9,032.00	One-off Purchase	Quotation issued via MultiQuote	N/A	First Submission
Alan Prosser	WBS	Q.0008/WBS	10/06/23	Quotation	Social Media Management Platform	Hootsuite Media	£21,609.01	Renewal of contract	Quotation issued via MultiQuote	N/A	Repeat £16,595.01
Alan Prosser	WBS	Q.0009/WBS	13/07/23	Quotation	Gel Cards & Screening Cells	Biorad Labs	£22,521.85	Renewal of contract	Quotation issued via MultiQuote	N/A	Repeat £22,521.85
Alan Prosser	WBS	Q.0010/WBS	13/07/23	Quotation	HLA SSO Kits	IBG Immucor	£5,395.08	Renewal of contract	Quotation issued via MultiQuote	N/A	Repeat £4,202.11
David Powell	VEL	VEL-MIN-MULTIRA332654	19/07/23	Quotation	Art Consultant	Simon Fenoulhet	£19,337.47	One-off Requirement	Quotation issued via MultiQuote	N/A	First submission
David Powell	VEL	VEL-MIN-MULTIRA332708	20/07/23	Quotation	Environmental and Low Carbon Architectural Advisor	Professor Phillip Jones	£20,000.00	One-off Requirement	Quotation issued via MultiQuote	N/A	First submission
David Powell	VEL	VEL-MIN-MULTIRA332712	20/07/23	Quotation	Pharmacy and Medicine Management Services	Andrew Davies	£15,000.00	One-off Requirement	Quotation issued via MultiQuote	N/A	First submission
David Powell	VEL	VEL-MIN-MULTIRA332741	21/07/23	Quotation	Design Consultant	WKSpace Limited	£9,800.00	One-off Requirement	Quotation issued via MultiQuote	N/A	First submission
Carl James / Jason Hoskins	Estates	QUOTE (23-24) 12	Jul-23	Quotation	Supply and Replacement Theatre Lighting	TBC	TBC	One-off Requirement	3 Quote Exercise Carried out by Estates	N/A	First submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 24th June – 31st August 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)
Matthew Bunce / Chris Moreton	Finance	QUOTE (23-24) 14	14/08/23-31/03/24	Quotation	Permanent recruitment fee	CY Executive Resourcing Ltd	£24,500.00	One-off Requirement	Direct Award via Cirrus Framework	N/A	First submission
Carl James / Jason Hoskins	Estates	QUOTE (23-24) 16	Aug-23	Quotation	Removal of Asbestos in CIU Boilers	Lorne Stewart	£12,000	One-off Requirement	3 Quote Exercise Carried out by Estates	N/A	First submission
Nicola Williams	Nursing	VCC-MQ-RA321766 CCN0001FR	1st October – 31st December 2023	CCN	Resus Training & Services	First Response Medical Training	3 Month Extension £6,125	Extension of contract required to provide time to carry out tender	Multiquote	Tender Closed and will be evaluated and awarded by 1st Jan 24	Repeat – Ann Value £24,500
Matthew Bunce / Chris Moreton	Finance	VEL-MIN-52136 CCN001SS	6 – 12 months commence Feb 23	CCN	Value Based Healthcare Analytics	The PSC	50% Increase £148,191.00	Increase 50% modification to carry out phase 2	Open Tender	N/A	Repeat - £296,382.00
Lauren Fear / Non Gwilym	Operational Services	VCC-MQ-RA321734	26th October – 25th October 2023	CCN	Newsletters for VCC	Hopp Studio	£20,470.00	Extend contract by 12 months due to delays with new project	Multiquote	Dept advised no spend against contract requested extend for another 12 months	Repeat – £0

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – 24th June – 31st August 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
Nicola Williams	Nursing	VEL	3 Years (started 21/06/2021)	File Note	Perfect Ward – Auditing Application	Perfect Ward Limited	£51,737.00	Contract commenced in 2021 with no engagement with Procurement.	Retrospective	Retrospective – Report to AC as breach	First submission
David Powell	VEL - New Velindre Cancer Centre	VEL-FN-029	01/04/2023 – 31/10/2023	File Note	Provision of M&E advice for the nVCC Project during the Successful Participant – Financial Close phase of the project	Hulley & Kirkwood	£45,000.00	Tender exercise undertaken but contract not signed off due to project team resource issues, continuation of ongoing advice which is essential for nVCC	Retrospective	Retrospective – Report to AC as breach	First submission
Lauren Fear	Corporate Governance	VEL-FN-030	05/06/2023 - 31/07/2023	File Note	Governance	Governance	£7,000.00	Procurement was not contacted by the department before the investigations took place	Retrospective	Retrospective – Report to AC as breach	First submission
Rachel Hennessy	VEL - Therapies	VEL-FN-031	03/07/2023 - 03/10/2023	File Note	Provision of Agency Staff for Therapies	Globe Locums LTD	£18,000.00	The team raised req 800225621 with the supplier without seeking procurement involvement on this agency procurement	Competition not sought in accordance with SFI'S	Advised department to contact Procurement for any requirements above £5k	First submission
Rachel Hennessy	VEL - Therapies	VEL-FN-032	25/07/2023 - 25/10/2023	File Note	Provision of Agency Staff for Therapies	Globe Locums LTD	£18,000.00	The team raised req 800225623 with the supplier without seeking procurement involvement on this agency procurement	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-034	One Off Requirement	File Note	Moving House Arts Project	Jude Rogers	£5,600.00	Procurement was not contacted by the department before the services took place.	Competition not sought in accordance with SFI'S	The n VCC Project have been advised that this will be reported to AC and to contact Procurement to carry out any due diligence for any future requirements moving forward.	First submission
Matthew Bunce	Finance	VEL-FN-035	March 2023	File Note	Financial Support Officer via Agency	Hoop Recruitment / Quba	£27,000.00	PO not raised prior to commencement of services.	Competition not sought in accordance with SFI'S	Retrospective – Noted - Procurement have advised that the total value is reported to Audit committee as the contract was entered into without	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
										procurement involvement.	
Jaz Abrahams	R&D	VEL	30/06/2023 - 29/06/2024	File Note	12 Months Subscription Services for Rita Chatbot IBM Watson (712176188)	IBM United Kingdom Ltd	£9,359.52	This has been a rolling contract, no procurement involvement.	Retrospective	Procurement have added this to workplan to ensure this is picked up next year.	First submission

Velindre University NHS Trust - Audit Committee Report – 24th June – 31st August 2023

Appendix 1.3 - Exemptions

Executive / Director Responsible	Division	Procurement Ref No	Period	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
Lauren Fear	Corporate Governance	VEL-FN-033	11/04/2023 - 20/07/2023	File Note	Legal Services for COVID-19 Public Inquiry	Hailsham Chambers	£12,200.00	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.	First submission
Alan Prosser	WBS	2324/002/WBS	N/A	SQA	Vehicle repairs	Sytner Cardiff	£6,494.57	Damage caused to a staff members car in WBS Car Park (falling tree). DOF Agreed under the losses & compensation procedure to fund the repairs. Sytner were contracted as an authorised BMW dealer to ensure no derogation of warranty.	One off purchase	Approved on basis that only a BMW garage could repair the damage to avoid invalidating the warranty of the vehicle.	First submission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – July 2023 – September 2023

Appendix 1.4 - All Wales Contracts in progress

During the period **July 2023 – September 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 1.4**.

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. 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)	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+
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

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+
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**	briefing	£44,200,800	09/08/2023	sent to WG 9/8	NA	NA

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+
	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						
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 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	ratification	£1,908,142	04/08/2023	18/09/2023	Sent to NF 21/9	
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	ratification	£600,000	16/08/2023	21/08/2023	NA	NA

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+
	replacement. Alongside enabling BCU to fulfil new hardware requests and project implementations.						
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 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	briefing	£32,000,000	05/09/2023	NA as formularly	NA	NA
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**	ratification	£2,334,124	21/09/2023	sent to WG 21/9		

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+
	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)						
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			

AUDIT COMMITTEE

DECLARATIONS OF INTERESTS, GIFTS, SPONSORSHIP, HOSPITALITY & HONORARIA (31 MAY 2023 – 06 OCTOBER 2023)

DATE OF MEETING	19/10/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	**FOR NOTING**

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	This report details the Declarations of Interests, Gifts, Sponsorship, Hospitality and Honoria received for the period **31/05/2023 – 06/10/2023.** • There have been 15 new entries on the Gifts, Hospitality and Sponsorship Register this period – ***ref. Appendix 1***. • There have also been 2 amendments to the Declarations of Interest Register this period ***ref. Appendix 2.*** • No objections to approval were received in respect of the items of business considered.

RECOMMENDATION / ACTIONS	To **NOTE** the Declarations of Interests, Gifts, Sponsorship, Hospitality and Honoria received for the period **31/05/2023 – 06/10/2023.**

GOVERNANCE ROUTE – N/A

7 LEVELS OF ASSURANCE – N/A

APPENDICES
Appendix 1: Additional Entries to the Trust Gifts, Sponsorship, Hospitality and Honoraria Register
Appendix 2: Amendments to the Trust Declarations of Interest Register

1. SITUATION/ BACKGROUND

1.1 In line with the requirements of the Trust Standing Orders and the Trust Standards of Behaviour Framework Policy, a report from the Trust register is required to be received by the Audit Committee, which detail any Gifts, Sponsorship, Hospitality & Honoraria activities that have been approved, together with any amendments / additions to the interests that have been declared.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The form in the Standards of Behaviour Framework policy should be used to seek approval for receiving hospitality/sponsorship/gifts and this should help or prevent the omission of crucial information that the authorising officer requires making an informed decision on approval or rejection. The authorised signatories should also be scrutinising the declarations prior to authorisation, in order to ensure the correct information is captured on the form before it is sent to the Trust Headquarters.

2.2 The appendices include the new amendments and additional entries received for the period **31/05/2023 – 06/10/2023.**

- There have been **15** new entries on the Trust Gifts, Hospitality and Sponsorship Register this period.
- There have been **2** amendments /additions to the Trust Declarations of Interest Register this period.

2.3 The declarations received this period have been completed in accordance with the Standards of Behaviour Framework Policy and authorised by the appropriate Trust Officer.

2.4 All declaration forms are reviewed and checked by the Head of Corporate Governance and any queries addressed prior to entry on the register.

2.4 Please refer to the register for the Declaration of Gifts, Hospitality and Sponsorship included at **Appendix 1** and the Declarations of Interest Register at **Appendix 2**.

3 IMPACT ASSESSMENT

<table>
<tr><th colspan="2">TRUST STRATEGIC GOAL(S)</th></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
YES - Select Relevant Goals below</td></tr>
<tr><td colspan="2">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 ☐</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>10 - Governance</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below
Safe ☐
Timely ☐
Effective ☒
Equitable ☐
Efficient ☒
Patient Centred ☐</td></tr>
<tr><td>The Register and Declaration of Interests is the method by which the Trust safeguards against conflict or potential conflict of interest where private interests and public duties of members of staff do not concur.

The Trust must be impartial and honest in the conduct of its business and must ensure that employees remain beyond suspicion at all times.</td></tr>
</table>

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	N/A
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Please refer to the detail within the registers at Appendix 1 and 2.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1 – Gifts, Sponsorship, Hospitality and Honoraria Register (Additional Entries: 31/05/2023 – 28/09/2023.)

Date Entry Received for Register	Name	Designation or Department	Division	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
06/06/2023	David Mason - Hawes	Head of Digital Delivery	Digital Services Corporate	Adam Stolasrski	20/06/2023 – 23/06/2023	x2 night Hotel accommodation with meals Airport transfer to and from Limerick Airport	Site visit to DELL Technologies Innovation centre in Limerick Ireland, to establish a view of current and future technologies to be used in the new Velindre Cancer Centre.	Accommodation: £350 (estimated) Meals/Refreshments: £75 (estimated)	Trust Time	N/A	Carl Taylor, Chief Digital Officer	06/06/2023	Accepted
06/06/2023	Daniel Rainbird	Deputy Head of Digital Infrastructure	Digital Services Corporate	Adam Stolasrski	20/06/2023 – 23/06/2023	x2 night Hotel accommodation with meals Airport transfer to and from Limerick Airport	Site visit to DELL Technologies Innovation centre in Limerick Ireland, to establish a view of current and future technologies to be used in the new Velindre Cancer Centre.	Accommodation: £350 (estimated) Meals/Refreshments: £75 (estimated)	Trust Time	N/A	Carl Taylor, Chief Digital Officer	06/06/2023	Accepted
06/06/2023	Gareth Daniels	Head of Digital Infrastructure	Digital Services Corporate	Adam Stolasrski	20/06/2023 – 23/06/2023	x2 night Hotel accommodation with meals Airport transfer to and from Limerick Airport	Site visit to DELL Technologies Innovation centre in Limerick Ireland, to establish a view of current and future technologies to be used in the new Velindre Cancer Centre.	Accommodation: £350 (estimated) Meals/Refreshments: £75 (estimated)	Trust Time	N/A	Carl Taylor, Chief Digital Officer	06/06/2023	Accepted

Date Entry Received for Register	Name	Designation or Department	Division	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
06/06/2023	Ian Taylor	Head of Digital Infrastructure Design	Digital Services Corporate	Adam Stolasrski	20/06/2023 – 23/06/2023	x2 night Hotel accommodation with meals Airport transfer to and from Limerick Airport	Site visit to DELL Technologies Innovation centre in Limerick Ireland, to establish a view of current and future technologies to be used in the new Velindre Cancer Centre.	Accommodation: £350 (estimated) Meals/Refreshments: £75 (estimated)	Trust Time	N/A	Carl Taylor, Chief Digital Officer	06/06/2023	Accepted
31/05/2023	Valerie Harris	Immunotherapy Lead Nurse	Integrated Services	Merck & BMS pharmaceutical companies	06/06/2023 & 12/06/2023 (Merck) 16/06/2023 & 30/06/2023 (BMS)	Merck virtual meetings: 6th and 12th June (1 hour each meeting) BMS virtual meetings: 16th June & 30th June (1hour each meeting)	Merck: Presenting 2 virtual one hour sessions on: Explaining adjuvant immunotherapy to renal & melanoma patients to professional staff within our LHBs. BMS: Presenting 2 virtual one hour sessions on: managing toxicities of immunotherapy to CNS from local heath boards.	Honoraria: £110 per hour	Own Time	Honorarium to reflect hours worked	Matthew Walters, Operational Lead Nurse		Accepted

Date Entry Received for Register	Name	Designation or Department	Division	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
22/06/2023	Bethan Tranter	Chief Pharmacist	Pharmacy	Ni Medical Info	13/09/2023	Annual award dinner and ceremony.	Judge for one of the awards	Meal: £50 (estimated)	Own Time	N/A	Paul Wilkins, Divisional Director	21/06/2023	Accepted
26/06/2023	Bethan Tranter	Chief Pharmacist	Velindre Cancer Centre	General Pharmaceutical Council (regulator)	12/07/2023	Dinner at St David's Spa Hotel Cardiff	Invited as a leader of the pharmacy profession in Wales to "have discussions with Council members, to inform their understanding of the pharmacy and wider health and care landscape in and to help shape the GPhC's strategic approach."	Meal: £75 (estimated)	Own Time	N/A	Paul Wilkins, Divisional Director	19/06/2023	Accepted

Date Entry Received for Register	Name	Designation or Department	Division	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
06/06/2023	Carl Taylor	Chief Digital Officer	Digital Services Corporate	MAK-System – Contact: Clement Glinkowski | c.glinkowski@mak-system.net c/o 10 Avenue de la Grande Armee 75017 Paris France	13/06/2023 – 15/06/2023	MAK-System International User Group (IMUG) – twice yearly meeting that takes place between MAK-System and all customers of its ePROGESA blood management IT system (and other IT software in the MAK portfolio).	The meeting is currently chaired by the Head of Digital Delivery, VUNHST.	Meal: £75 (estimated) Other: (MAK Merchandise: £100 (estimated)	Trust Time	N/A	Carl James, Executive Director of Director of Strategic Transformation, Planning and Digital	06/06/2023	Accepted
06/06/2023	David Mason Hawes	Head of Digital Delivery	Digital Services Corporate	MAK-System – Contact: Clement Glinkowski | c.glinkowski@mak-system.net c/o 10 Avenue de la Grande Armee 75017 Paris France	13/06/2023 – 15/06/2023	MAK-System International User Group (IMUG) – twice yearly meeting that takes place between MAK-System and all customers of its ePROGESA blood management IT system (and other IT software in the MAK portfolio).	The meeting is currently chaired by the Head of Digital Delivery, VUNHST.	Meal: £75 (estimated) Other: (MAK Merchandise: £100 (estimated)	Trust Time	N/A	Carl Taylor, Chief Digital Officer	06/06/2023	Accepted

Date Entry Received for Register	Name	Designation or Department	Division	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
06/06/2023	Emyr Adlam	Head of Digital Applications	Digital Services Corporate	MAK-System – Contact: Clement Glinkowski | c.glinkowski@mak-system.net c/o 10 Avenue de la Grande Armee 75017 Paris France	13/06/2023 – 15/06/2023	MAK-System International User Group (IMUG) – twice yearly meeting that takes place between MAK-System and all customers of its ePROGESA blood management IT system (and other IT software in the MAK portfolio).	The meeting is currently chaired by the Head of Digital Delivery, VUNHST.	Meal: £75 (estimated) Other: (MAK Merchandise: £100 (estimated)	Trust Time	N/A	Carl Taylor, Chief Digital Officer	06/06/2023	Accepted
25/09/2023	Dr Simon Waters	Consultant	Velindre Cancer Service	Eli Lilly & Co., Ltd	21/09/2023	Evening Meeting (6-9pm): Cardiff Satellite Meeting UK Affiliate 2023 Regional HEM London	Chairing	Honorarium - £705	Own Time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	24/09/2023	Accepted
25/09/2023	Dr Simon Waters	Consultant	Velindre Cancer Service	Eli Lilly & Co., Ltd	11/10/2023	Evening Meeting (6-9pm): Clinical Management of Abemaciclib	Chairing	Honorarium - £540	Own Time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	24/09/2023	Accepted
02/10/2023	Chris Moreton	Deputy Director of Finance	Finance, Corporate	The PSC, 1 Finsbury Ave, London EC2M 2PF	27/09/2023	Offer of Evening Dinner in Cardiff	N/A – declined due to availability	Hospitality	Own Time	N/A	Matthew Bunce, Executive Director of Finance	02/10/2023	Declined
02/10/2023	Gwaer Evans	Head of Value Based Healthcare	Finance, Corporate	The PSC, 1 Finsbury Ave, London EC2M 2PF	27/09/2023	Offer of Evening Dinner in Cardiff	Opportunity to network with representatives from PSC to discuss VBHC and broaden knowledge on the national plan.	Hospitality, Meals/Refreshments: £30	Own Time	N/A	Matthew Bunce, Executive Director of Finance	26/09/2023	Accepted

Date Entry Received for Register	Name	Designation or Department	Division	Provided by / From	Date Received	Details	Reason	Gift, Hospitality and/or Sponsorship	Was the activity/ event undertaken in the individuals own time, study leave, Trust time?	For Honoraria Only - Identify if receipt was for work in individuals own time, or directly into Trust funds	Authorised by	Date Approved	Accepted or declined
06/10/2023	Matthew Bunce	Executive Director of Finance	Finance, Corporate	Victoria Hughes, Liaison Group, Liaison Court, Vincent Road, Worcester, WR5 1BW.	13/09/2023	Liaison Group brought donuts, mugs, stationery (diaries, pens, and calculator), and bag of chocolates to Velindre Trust Headquarters. The gifts were shared with all staff in Trust HQ.	Accepted from company the Trust had already awarded a contract to for provision of Private Patient advice and support. The gifts were shared with all staff in Trust HQ.	Gift	N/A	N/A	Steve Ham, Chief Executive	06/10/2023	Accepted

Appendix 2 – Trust Declarations of Interest Register

DESIGNATION	Name	Date Received	Division	Details
Independent Member	Professor Andrew Westwell	12/09/2023	Corporate	• Professor of Medicinal Chemistry (School of Pharmacy and Pharmaceutical Sciences, Cardiff University), Teaching and Research role (F/T); August 2018 - present (remunerated - salary) • Scientific Advisory Committee member, TNA Therapeutics Inc.; May 2023 - present (share options)
Charity Director	Paul Wilkins	28/09/2023	Corporate	• Nil Interests Declared

AUDIT COMMITTEE

INTERNAL AUDIT REPORT: Digital Strategy & Transformation Programme

DATE OF MEETING	19th October 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	Emma Rees, Deputy Head of Internal Audit / Simon Cookson Director of Audit and Assurance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	The purpose of this report is to present the Digital Strategy and Transformation Programme.

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 implementation of the Trust's Digital Strategy.

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 a Digital Strategy in place and has defined an appropriate operating model that is being implemented to enable delivery of the Digital Strategy.

The Digital Strategy considers digital inclusion, although we note that delivery on the actions in this area is at an early stage. The Digital Strategy also considers the technology in use within the organisation.

Successful delivery of the Digital Strategy will require a cultural shift within the organisation to a truly digital first culture.

The key management actions identified are:

- Ensuring the governance framework enables appropriate visibility of digital.
- Ensuring a transition to a digital culture.
- Ensuring the delivery of the digital inclusion action plan and communication of the aims of digital.

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*	07 - Digital Transformation - Failure to Embrace New Technology
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 IMTP objectives; • TAF 07 – Digital Transformation.
WHAT IS THE CURRENT RISK SCORE	Linked to five 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	

Digital Strategy & Transformation Programme

Final Internal Audit Report

August 2023

Velindre University NHS Trust

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Contents

Review reference:	VT2324 – 02
Report status:	Final
Fieldwork commencement:	16 May 2023
Fieldwork completion:	21 July 2023
Debrief meeting:	21 July 2023
Draft report issued:	22 August 2023
Management response received:	8 October 2023
Final report issued:	10 October 2023
Auditors:	Martyn Lewis, IT Audit Manager
Executive sign-off:	Carl James, Director of Strategic Transformation, Planning & Digital
Distribution:	Carl Taylor, Chief Digital Officer David Mason-Hawes, Head of Digital Delivery
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.

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

The objective of the audit was to provide assurance over the implementation of the Trust's Digital Strategy.

Overview

We have issued reasonable assurance on this area.

The Trust has a Digital Strategy in place and has defined an appropriate operating model that is being implemented to enable delivery of the Digital Strategy.

The Digital Strategy considers digital inclusion, although we note that delivery on the actions in this area is at an early stage. The Digital Strategy also considers the technology in use within the organisation.

Successful delivery of the Digital Strategy will require a cultural shift within the organisation to a truly digital first culture.

The key management actions identified are:

- Ensuring the governance framework enables appropriate visibility of digital.
- Ensuring a transition to a digital culture.
- Ensuring the delivery of the digital inclusion action plan and communication of the aims of digital.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	None

Assurance summary[1]

Objectives		Assurance
1	Progress	Reasonable
2	Digital Operating Model	Reasonable
3	Digital literacy & Inclusion	Reasonable
4	Older Technology	Reasonable

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Publication of Digital Strategy	1	Operation	Medium
2	Governance Framework	1	Operation	Medium
3	Digital Culture	2	Operation	Medium
4	Digital Inclusion	3	Operation	Medium
5	Older Technology Impact	4	Operation	Medium

1. Introduction

1.1 In line with the 2023/24 Internal Audit Plan for Velindre University NHS Trust (the 'Trust' or 'organisation') a review of the Digital Strategy and Transformation Programme was undertaken.

2. Detailed Audit Findings

Objective 1: Appropriate progress is being made in implementing the Trust's Digital Strategy, with appropriate reporting and oversight maintained.

2.1 There is a Digital Strategy in place for the Trust, this links to the organisation's 5 strategic goals, and defines digital in terms of Velindre services users and staff by using user stories, including for a cancer patient and a blood donor.

2.2 We note that although the digital strategy has been approved, it has not been published or made widely available. As such, the Trust is not communicating or pushing forwards on its aims as a digital first organisation. **Matter Arising 1**

2.3 The strategy provides context in terms of changes that have already been made in the structure of digital and the leadership and governance framework, and notes the need for a culture change within the organisation for digital transformation to be successful.

2.4 The strategy provides a vision which is broken down into themes, each of these has objectives and specific actions, the themes being:

- Ensuring foundations;
- Digital inclusion;
- Safe and secure services;
- Working in partnership;
- Digital organisation; and
- Insight driven services.

2.5 The Trust's IMTP references the Digital Strategy in a number of areas, with it being identified as a supporting and enabling strategy. The IMTP also notes the link to divisional objectives and the Velindre Futures and includes the digital plan as an appendix.

2.6 As part of our audit work, we tracked the progress of a number of actions and objectives within the Digital Strategy. We note that progress is being made against the digital objectives, with some key actions noted:

- Work has started to define and implement a new strategy for telephone services;
- A proposal has been submitted for a revised approach to business intelligence;
- Work is underway to enable outcome reporting (PROMS) under the Value Based Healthcare programme;

- A supplier engagement programme is being developed which will better enable linkages with suppliers and academia; and
- Work is continuing to improve the cyber security position of the Trust.

2.7 There is a framework for governance and oversight of digital, although we note that the reporting arrangements are split across Committees, with no single committee in place that is responsible for digital.

2.8 The Strategic Development Committee has responsibility for oversight of the Digital Strategy itself, with the Quality, Safety and Performance Committee having oversight of the operational delivery of digital. We also note that there is reporting to the Executive Management Board (EMB), and digital forms part of the performance management framework. Digital is also integrated into the divisional programmes with reporting and decision making at the Velindre Futures forum and with the WBS modernisation programme.

2.9 Our review of Committee business confirmed that this governance structure is operating as defined, with regular reporting on the relevant aspects of digital to each committee.

2.10 The nature of the current governance structure for digital is spread across a number of governance arrangements therefore, there is no single forum where it comes together with full oversight. This means that whilst Digital is being discussed at a broad range of places and avoids siloes there is a potential for the committees and leads to miss opportunities to gain a full picture.

2.11 We also note that, although there is a Chief Digital Officer (CDO), there is no named Director of Digital role Whilst there is a difference in name the CDO performs similar duties albeit without being an Executive level role. The current arrangement is working appropriately however with the CDO attending core groups and committees and the lead executive being engaged in digital issues. We note that there is a trend within NHS Wales to establish a Director of Digital role as a full Executive role.

2.12 The fragmented governance arrangements and the lack of a digital director may mean that digital is not fully visible, in particular outside the Trust and as such may not be matching the Trust's stated "digital first" ambition. **Matter Arising 2**

2.13 Our review of the detail contained in the reporting to committees confirmed that reporting accurately reflects the current picture and includes reporting on key risks to the achievement of digital objectives.

Conclusion

2.14 The Trust has an approved Digital Strategy which is clear about the aims of the Trust and contains key actions and objectives to drive digital transformation, although we note that it has not yet been published. The Digital Strategy is linked to the overall Trust Strategy and IMTP and progress is being made on delivery of key items within the Digital Strategy. There is a governance and oversight framework in place for digital and reporting within this framework is accurate. We note however that the framework is split across multiple groups and so the visibility

of digital may not fully reflect the Trust's stated ambitions. Accordingly, we have provided **reasonable assurance** over this objective.

Objective 2: The organisation has defined an appropriate digital operating model that supports staff and enables transformation, together with a roadmap for implementation of the Digital Strategy.

2.15 An appropriate target digital operating model has been set out in order to define how digital services are to be structured in order to deliver the Digital Strategy, in particular at a high level, with a more detailed operating model to be developed following external consultancy work. This model contains 4 key themes:

- Digital Service Design;
- Digital Integrated Platform;
- Digital Organisation; and
- Ecosystem.

2.16 We note that the Trust has a large programme of digital transformation work due to both Velindre Futures and the WBS modernisation. The focus on transformation may lead to the day-to-day support function being under resourced and a lack of ability to improve extant services. As part of the implementation of the operating model, the service management framework is to be developed to better support the organisation in addition to enabling digital transformation. We note that the Digital team has been restructured and now it is just one team, with one service desk.

2.17 The implementation of the digital model is to be via a digital programme that brings all the elements together and defines a governance structure for management. A paper to this effect and seeking approval was presented to the SDC (December 2022) and EMB (June 2023). This has been approved, and the programme is currently being established.

2.18 The operating model as defined enables the alignment of people, processes and technology in order for digital to support the organisational objectives.

2.19 Within the digital service the model shows the creation of "digital squads" to enable links with operational services and agile development. We also note the intent within the Digital Organisation theme to establish a digital champions network to further link digital with services.

2.20 Digital services have developed a Digital Services Resource plan to define the resource need, both in terms of skills and number of staff, which is needed to provide the required service for the organisation. Work was undertaken to improve the resourcing following this, and we note that there is an explicit intent to redo this work in light of the new operating model in order to ensure that all the required skills are considered. There is also work ongoing both within DHCW and HEIW to define the required digital skills across NHS Wales.

2.21 In terms of skills within the wider organisation, the digital model theme "Digital Organisation" explicitly includes skills development, with an objective to develop a digital education and training programme. In addition, the "Digital Ecosystem"

theme includes digital inclusion for patients and donors and the use of universities and technical partners for delivery of digital products.

2.22 The Digital Design theme sets out an overall process for delivering digital services with a flow from discovery to development to live. This enables service processes to be reassessed and redesigned, and we note the intent to create long term ownership of services and to design clinically led services which would embed digital within the organisation.

2.23 The model sets out a mechanism to define the appropriate technology within the Digital Integrated Platform theme, which is split into reference architecture, essential and core services, tailored services and data and insight services.

2.24 The current model sets out some specifics for technology, with Office 365 being included, along with a requirement for cloud-based services. In addition, the model references both the National Data Repository and Local Data Repository in terms of the insight services.

2.25 We note that the Trust is a heavy user of, and therefore is reliant on, the national systems provided by DHCW. This may act as a drag as the Trust has limited influence on both development and timing, and as such may not be able to maximise the potential presented by the new cancer centre and WBS modernisation.

2.26 The Strategy does not explicitly contain a roadmap that defines how the objectives and actions will be delivered across the organisation, with no timescales set for actions. The Trust has engaged an external consultancy to assist in the development of the digital structures within the Trust and this includes setting out a roadmap for delivery of the new operating model.

2.27 The component projects which make up the Digital Strategy are identified across a variety of documents, including the strategy itself, the IMTP and the Digital Workplan. These all include lead officers and indications of timeframes, and as such provide a roadmap for delivery of the strategy objectives.

2.28 We note that there are resource gaps identified within the digital plan, and work is currently underway to identify resources (staff) to mitigate these.

2.29 We also note that there is ongoing work to develop sub-strategies and plans to support the digital strategy, including:

- Architecture;
- Software development; and
- Service desk and support.

2.30 We note however, that although the organisation has stated a commitment to “digital first” and is putting plans in place, the current picture does not show this and in similar to other organisations in NHS Wales digital is not fully embedded with services.

2.31 For the operating model to effectively work to deliver the strategy, the organisational culture needs to be a digital one, where digital is embedded and there

is ownership of digital from top to the bottom. We note that Velindre is not yet within this space, with the Digital Programme still being formed at the Executive level, with the lack of a single top-level group to coordinate and own digital, a lack of full understanding of digital at operational level and the organisation retaining some silos in relation to digital work. **Matter Arising 3**

2.32 The model contains a digital programme of work alongside the divisional modernisation programmes, however there is currently a lack of clarity over where some items should sit would rest, with it currently being at EMB.

2.33 We note that this is changing, and the model is being established, however until the understanding of digital is there it won't be fully effective.

Conclusion:

2.34 The Trust has defined an operating model which is being implemented in order to deliver on the Digital Strategy's objectives. The operating model appropriately covers the key components, including people, processes and technology. We note that delivery of this model relies on a digital culture within the wider organisation however this is not yet fully in place. There is a roadmap that defines how the Digital Strategy components will be implemented and resource gaps are being identified. Accordingly, we have provided **reasonable assurance** over this objective.

Objective 3: Processes are in place to ensure the digital literacy of staff and digital inclusion for service users is sufficient to enable delivery of digital transformation.

2.35 The Digital Strategy specifically considers the digital competencies of staff within the Digital Organisation theme, which notes a requirement to strengthen digital education and training and work to develop the core digital competence of the workforce. The key objectives within this are stated as:

- Create strong digital leadership at all levels of the organisation;
- Build a highly skilled digital team that has the capacity and capability to deliver our digital ambitions; and
- Create a digitally literate workforce which embraces the use of technology to improve the services we provide.

2.36 There is a recognition of the need to develop staff competency, the digital competency of staff is also included within Digital Inclusion theme, and there are specific actions defined to improve and develop staff skills. These actions include digital skills audits; developing a digital champions network; resuming Office 365 deployment; providing guides; and a programme of lunch and learn sessions.

2.37 A digital inclusion action plan has been drafted which includes all the key items to improve staff digital competence, however we note that many of the actions are at an early stage, or have yet to commence. In particular, although a profile for a digital champion has been drafted, there has been no identification of these, and the range of information on the learning system is limited at present to materials related to the Cansic replacement, with no information on digital issues or O365.

2.38 There has been some information delivery and as part of the learning at work week there were sessions on Microsoft forms, Teams and user centred design.

2.39 As noted above the organisational culture is not currently a digital one and staff do not always understand what digital means and the role of the digital directorate together with their role in ensuring digital delivery. The identification of champions alongside the communication of digital intent and a strong programme of digital skills development is key to ensuring that the organisation culture changes. **Matter Arising 4**

2.40 The Digital Strategy is explicit on the need to ensure all patients / donors are included and able to use digital offerings, with Digital Inclusion containing core objectives:

- Digitally connect our donors, patients and carers and staff to our services 24/7;
- Place information which is uncomplicated and accessible into the hands of patients and donors to enable them to make better decisions about the services and support they require;
- Deliver the technology which supports the provision of more services at home and as locally as possible;
- Provide our staff with the technology to work from a wide range of locations across Wales; and
- Reduce digital exclusion of people across Wales.

2.41 The Trust is clear about how it wants to move forward in this space, has a stated ambition, has signed the Digital Inclusion Charter and developed an accreditation action plan. The Trust also has representation on the Digital Inclusion Alliance for Wales and so there is ongoing development of a wider community approach.

2.42 We note however that many of the core actions are at an early stage, and without digital inclusion work being in place the impact of the Trust's digital solutions may be reduced.

Conclusion:

2.43 The Digital Strategy explicitly considers digital inclusion and competency, and there are action plans in place in order to drive this forward. We note that delivery of this is at an early stage however, and the success of the implementation of the Digital Strategy and operating model will rely on this area moving forward. Accordingly, we have provided **reasonable assurance** over this objective.

Objective 4: Processes are in place to identify out of date technology and the level of technical debt and mitigate the risks resulting in these in relation to the delivery of the Digital Strategy.

2.44 We note that the Trust contains legacy technology, both hardware and software.

2.45 In order to fully identify and baseline the services in place an external consultancy has been engaged. As part of this discovery work the requirement to baseline the current technologies was noted.

2.46 The older hardware in place is identified and we note that there has been good progress in removing and updating this.

2.47 The risks associated with the existence of legacy technologies have been noted within the Trust's risk management process. The Trust risk register includes two high rated risks (2774 and 2776) relating to the use of older technology within WBS, in particular LIMS, which notes the impact on delivery of services. There are also additional, lower scored risks held on the digital services risk register relating to the presence of older technology which focus on the risk of disruption and loss of service.

2.48 The new cancer centre, and the WBS modernisation programme offer opportunities for digital transformation and service redesign using modern technology and agile digital delivery. The use of older IT systems can act as a constraint and lead to a risk to the delivery of the Digital Strategy and successful digital transformation, however the risks as currently stated do not fully articulate this. **Matter Arising 5**

2.49 The Digital Strategy includes a theme in relation to the use of technology, Ensuring Foundations, the key objectives of which include:

- Develop 'fit-for-the future' technologies that are resilient with a hybrid of cloud and data centre / on premise deployment;
- Design all systems around the national principles (e.g. open; inter-operable;) to support integration across organisations;
- Implement a range of national systems, to support a once for Wales approach, including Welsh Clinical Portal, Welsh Patient Administration System, Welsh Laboratory Information Systems and electronic prescribing;
- Continually develop and maximise the benefits of our existing business systems, including the Blood Establishment Computer System (eProgesa) and Digital Health Care Record;
- Implement local solutions relevant and appropriate to the needs of the population we serve; and
- Design and implement a new strategy for the telephony services used across the Trust, to include the adoption of new digital telephony services, such as those available via Microsoft Teams.

2.50 As such the Digital Strategy sets out an aim to ensure that the Trust uses modern technology for the delivery of services.

2.51 As noted previously the new cancer centre and the WBS modernisation programme offer opportunities to deploy modern digital applications and technologies. We note that a more detailed roadmap to modernisation will be developed following the baselining work currently underway.

Conclusion:

2.52 There are processes in place to identify older technology in use and there are actions defined in order to mitigate the risks resulting from these. The use of older technologies presents a risk to the successful delivery of digital transformation, however this aspect of the risk is not fully articulated. Accordingly, we have provided **reasonable assurance** over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Digital Strategy Publication (Operation)			Impact
We note that although the Digital Strategy has been approved, it has not been published or made widely available. As such the Trust is not communicating or pushing forwards on its aims as a digital first organisation.			There may be a lack of clarity and understanding of the Trusts digital intent
Recommendations			**Priority**
1.	The digital Strategy should be published, and a communications exercise undertaken to publicise the strategy and the Trusts digital intent.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
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.	31st October 2023	Chief Digital Officer

Matter Arising 2: Governance Framework. (Operation)	Impact
The nature of the current governance structure for digital is fragmented with no single forum where it comes together with full oversight. This means that there is a potential for the committees and leads to miss opportunities to gain a full picture. We also note that although there is a Chief Digital Officer, there is no Director of Digital. The current arrangement is working appropriately with the CDO attending core groups and committees and the lead executive being engaged in digital issues. We note that there is a trend within NHS Wales to establish a digital director role The fragmented governance arrangements and the lack of a digital director may mean that digital is not fully visible, in particular outside the Trust and as such may not be matching the Trust's stated "digital first" ambition.	The visibility of digital may be lacking compared to the Trust ambition.

	Recommendations	Priority
	The governance structure for digital should be re-considered, with further consideration given to establishing a group where all digital items are considered.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
	A Digital Programme Group is being established which will bring Digital together for oversight into the Executive Management Board. 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	31st October 2023 for Digital Programme Group 30th November for Exec/Board Review	Chief Digital Officer Director of Strategic Transformation, Planning & Digital

Matter Arising 3: Digital Culture. (Operation)	Impact
Although the organisation has stated a commitment to “digital first”, the current picture does not show this and digital is not embedded with services. For the operating model to effectively work to deliver the strategy, the organisational culture needs to be a digital one, where digital is embedded and there is ownership of digital from the top to the bottom. We note that Velindre is not yet within this space, with the lack of a top-level group to coordinate and own digital, a lack of full understanding of digital at operational level and the organisation retaining silos in relation to digital work. The model contains a digital programme of work alongside the divisional modernisation programmes, however there is currently a lack of clarity over where some items should sit would rest, with it currently being at EMB.	Successful delivery of the Digital Strategy and operating model may be impacted

Recommendations		Priority
	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**

	Agreed Management Action	Target Date	Responsible Officer
	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.	31st October 2023	Chief Digital Officer

Matter Arising 4: Digital Inclusion. (Operation)	Impact
Many of the core actions relating to digital inclusion and competency are at an early stage, and without digital inclusion work being in place the impact of the Trust's digital solutions may be reduced. As previously noted the organisational culture is not currently a digital one and staff do not always understand what digital means and the role of the digital directorate together with their role in ensuring digital delivery. The identification of champions alongside communication of digital intent and a strong programme of digital skills development is key to ensuring that the organisation culture changes	Successful delivery of the Digital Strategy and operating model may be impacted

	Recommendations	Priority
	Work to progress the digital inclusion action plan and digital skills and awareness within the organisation should be accelerated.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
	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	30th November 2023	Chief Digital Officer

Matter Arising 5: Older Technology Risks. (Operation)	Impact
The new cancer centre, and the WBS modernisation programme offer opportunities for digital transformation and service redesign using modern technology and agile digital delivery. However, the use of older IT systems can act as a constraint and lead to a risk to the delivery of the Digital Strategy and successful digital transformation. However, the risks as currently stated do not fully articulate this.	Successful delivery of the Digital Strategy and operating model may be impacted

	Recommendations	Priority
	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**

	Agreed Management Action	Target Date	Responsible Officer
	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	31st October 2023	Chief Digital Officer

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

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