Public Audit Committee

Tue 25 April 2023, 10:00 - 12:30

Velindre UNHS Trust Headquarters

Agenda

10:00 - 10:00
0 min

1.0.0 STANDARD BUSINESS

Led by Martin Veale, Chair of the Audit Committee

1.1.0 Apologies

Led by Martin Veale, Chair of the Audit Committee

1.2.0 In Attendance

Led by Martin Veale, Chair of the Audit Committee

1.3.0 Declarations of Interest

Led by Martin Veale, Chair of the Audit Committee

1.4.0 Draft Minutes from the Public Part A Audit Committee meeting held on 12 January 2023

Led by Martin Veale, Chair of the Audit Committee

1.4.0 DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 12 JANUARY 2023 -LF MV (2) (002).pdf (14 pages)

1.5.0 Action Log

Led by Martin Veale, Chair of the Audit Committee

1.5.0 Audit Committee Action Log updates April 2023 Meeting (v2).pdf (11 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

2.1.0 Audit Committee Private Patient Report Apr'23.pdf (6 pages)
2.1.0 PP Action Plan 180423 Final.pdf (6 pages)

10:00 - 10:00
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3.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

3.1.0 Trust Risk Register (Oral Update)

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

3.2.0 Trust Assurance Framework (Oral Update)

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

3.3.0 Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit

Led by Matthew Bunce, Executive Director of Finance

- 3.3.0a Cover Paper - Audit Action Tracker April 2023 2023 Audit Committee.pdf (16 pages)
- 3.3.0b Audit Action Tracker - April 2023 Audit Committee.pdf (75 pages)

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)

Led by Matthew Bunce, Executive Director of Finance

- 3.4.0 Reporting of Potential Risk of Formal Legal Challenge to Contract Award.pdf (1 pages)

10:00 - 10:00
0 min

4.0.0 EXTERNAL AUDIT

Led by Darren Griffiths (Audit Wales)

4.1.0 Auditor General for Wales NHS – Audit of Accounts 2022-23 letters

Led by (Audit Wales)

- 4.1.0a NHS covering letter final.pdf (2 pages)
- 4.1.0b NHS_letter_final_eng.pdf (7 pages)

4.2.0 Audit Plan

Led by Steve Wyndham and Katrina Febry (Audit Wales)

- 4.2.0 VUNHST Outline Audit Plan.pdf (10 pages)

4.3.0 Audit Position Update

Led by Steve Wyndham and Katrina Febry (Audit Wales)

- 4.3.0 VUNHST Audit Cmt 20230425 Audit Update.pdf (10 pages)

4.4.0 Annual Audit Report

Led by Katrina Febry (Audit Wales)

- 4.4.0 3369A2023_VUNHST_2022_Annual_Audit_Report_final.pdf (24 pages)

4.5.0 Structured Assessment Report

Led by Katrina Febry (Audit Wales)

- 4.5.0 3296A2022_VUNHST_2022_Structured_Assessment_Report_final.pdf (34 pages)

10:00 - 10:00
0 min

5.0.0 INTERNAL AUDIT

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

5.1.0 2022/23 Internal Audit Progress Update

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

- 5.1.0a VUNHST Audit Committee Progress Update Cover Paper - Jan-23.pdf (3 pages)
- 5.1.0b VUNHST Audit Committee Progress Update - Apr-23 (updated).pdf (11 pages)

5.2.0 2023/2024 Internal Audit Plan

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

- 5.2.0 VT Cover Paper - 2023-24 Internal Audit Plan - Apr-23 Audit Committee.pdf (6 pages)
- 5.2.0 Appendix 1 - VT_2023-24_Internal Audit Plan_for Audit Committee Approval.pdf (23 pages)
- 5.2.0 Appendix 2 - Internal Audit Assurance over Strategic Risk.pdf (1 pages)
- 5.2.0 Appendix 3 - Internal Audit Assurance over Trust Priorities.pdf (1 pages)

10:00 - 10:00
0 min

6.0.0 COUNTER FRAUD

6.1.0 Counter Fraud Progress Report Quarter 4 22/23

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

- 6.1.0 VUNHST Q4 COUNTER FRAUD PROGRESS REPORT.pdf (6 pages)

6.2.0 Annual Report 22/23

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

- 6.2.0 VUNHST COUNTER FRAUD ANNUAL REPORT 22-23 (002).pdf (13 pages)
- 6.2.0 VUNHST COUNTER FRAUD ANNUAL REPORT APPENDIX 1.pdf (7 pages)

6.3.0 Annual Plan 23/24

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

- 6.3.0 VUNHST COUNTER FRAUD ANNUAL PLAN 23-24.pdf (24 pages)

10:00 - 10:00
0 min

7.0.0 FINANCE

7.1.0 Private Patient Service Debt Position

Led by Rachel Hennessy, Interim Director of Velindre Cancer Centre

- 7.1.0 Audit Committee - Aged Debt Private Patient Service March 23 DO Update.pdf (6 pages)
- 7.1.0 Appendix 1 Aged Debt Private Patient Service March 23 DO Update.pdf (1 pages)

7.2.0 Losses and Special Payments Report

Led by Claire Bowden, Head of Financial Operations

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

10:00 - 10:00
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8.0.0 CONSENT AGENDA

Led by Martin Veale, Chair of the Audit Committee

8.1.0 FOR NOTING

Led by Martin Veale, Chair of the Audit Committee

8.1.1 Procurement Compliance Report

Led by Matthew Bunce, Executive Director of Finance

- 8.1.1 Procurement Com[pliance Report April 2023 Finalv2.pdf (20 pages)

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

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

8.1.2 DOI Gifts, Sponsorship, Hospitality and Honoria.pdf (10 pages)

8.1.3 Clinical Audit Report

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

8.1.3 VT 2223-10 Clinical Audit Final Internal Audit Report - Trust issue.pdf (22 pages)

8.1.4 Clinical Audit All-Wales Analysis Audit Report

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

8.1.4 VT 2223-10a - Clinical Audit All-Wales Themes Report - Trust issue.pdf (21 pages)

8.1.5 Information Governance Final Internal Audit Report

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

8.1.5 VT 2223-15 Information Governance Final Internal Audit Report.pdf (17 pages)

8.1.6 Capital Systems Audit Report

Led by Melanie Goodman, Audit Manager (NWSSP - Audit and Assurance Services)

8.1.6 VUT Capital Systems 22.23 Final Report.pdf (27 pages)

8.2.0 ENDORSEMENT FOR APPROVAL

Led by Martin Veale, Chair of the Audit Committee

8.2.1 Amendment to Standing Orders – Schedule 3

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

8.2.1 Amendments to Trust Standing Orders - Shedule 3 - Cover Paper.pdf (6 pages)
8.2.1 Appendix 1 - QSP with track changes.pdf (13 pages)
8.2.1 Appendix 2 - RDI& with track changes.pdf (9 pages)
8.2.1 Appendix 3 - CFC with track changes.pdf (8 pages)
8.2.1 Appendix 4 - QSP without track changes.pdf (13 pages)
8.2.1 Appendix 5 - RDI& without track changes - Copy.pdf (9 pages)
8.2.1 Appendix 6 - CFC without track changes.pdf (8 pages)

10:00 - 10:00
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9.0.0 HIGHLIGHT REPORT TO THE TRUST BOARD

10:00 - 10:00
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10.0.0 MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

10:00 - 10:00
0 min

11.0.0 ANY OTHER BUSINESS

- Audit Committee Effectiveness Survey

10:00 - 10:00
0 min

12.0.0 DATE AND TIME OF THE NEXT MEETING

Wednesday 26th July 2023 at 10:00AM

10:00 - 10:00
0 min

13.0.0 CLOSE

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

10:00 - 10:00
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MINUTES OF THE PUBLIC AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
THURSDAY 12 JANUARY 2023 AT 10:00AM

PRESENT:	
Martin Veale	Chair and Independent Member
Gareth Jones	Independent Member
Vicky Morris	Independent Member
ATTENDEES:	
Matthew Bunce	Executive Director of Finance
Lauren Fear	Director of Corporate Governance & Chief of Staff
Cath O'Brien	Chief Operating Officer
Chris Moreton	Deputy Director of Finance (Joined the meeting at 11:27AM)
Claire Bowden	Head of Financial Operations
Tracy Hughes	Financial Services & Accounting Manager
Rachel Hennessy	Interim Director of Velindre Cancer Centre
Felicity Quance	Senior Audit Manager, NWSSP (Audit and Assurance Services)
Emma Rees	Audit Manager, NWSSP (Audit and Assurance Services)
Martyn Lewis	Auditor, NWSSP (Audit and Assurance Services)
Paul Stocker	Audit Manager, NWSSP (Audit and Assurance Services)
Krisztina Kozlovszky	Internal Audit Manager, NWSSP (Audit and Assurance Services)
Darren Griffiths	Audit Wales
Gareth Lavington	Lead Local Counter Fraud Specialist
Alison Hedges	Business Support Officer

1.0.0	**Standard Business** Led by Gareth Jones, Chair, and Independent Member	**Action**
1.1.0	**Apologies** Led by Martin Veale, Chair, and Independent Member Apologies were received from: • Steve Ham, Chief Executive Officer • Jacinta Abraham, Executive Medical Director • Simon Cookson, Director of Audit & Assurance • Katrina Febry, Audit Wales • Steve Wyndham, Audit Wales • Helen James, Head of Procurement • Nigel Price, Local Counter Fraud Specialist	
1.2.0	**In Attendance** Led by Martin Veale, Chair, and Independent Member Martin Veale welcomed attendees from Audit Wales and Internal Audit Services to the Audit Committee Meeting. Martin Veale was also pleased to advise Krisztina Kozlovszky, Internal Audit Manager, NWSSP (Audit and Assurance Services) and Tracy Hughes, Financial Services & Accounting Manager had joined the meeting as observers.	
1.3.0	**Declarations of Interest** Led by Martin Veale, Chair, and Independent Member No declarations of interest were declared.	
1.4.0	**Action Log** Led by Martin Veale, Chair, and Independent Member **05/2022 6.0.0 Internal Audit Report: DBS Checks** Lauren Fear confirmed The Paper being shared with EMB in January 2023 is the latest position and will need to track this action until it's closed.	

	Gareth Jones raised concerns that in a previous meeting the target date was deemed too far away, and the draft procedure still isn't approved by Trade Union colleagues and the Safeguarding Group, so expressed the need to see a degree of urgency on this action. Vicky Morris explained there is a Tracker that they use at Quality Safety and Performance Committee for all policies that need to be updated. She suggested that this be picked up following through to QSP so that its back on the Tracker and this should then support Gareth Jones' point. **07/2022 2.2.1 Procurement Compliance Report – Draft Protocol** Meeting has been scheduled for Matthew Bunce, Gareth Jones, Andy Butler, Jonathan Irvin, and Lauren Fear on the 8th of February 2023. Martin Veale to also be formally invited. **07/2022 2.2.1 Procurement Compliance Report – Procurement Framework Agreement Review** This action will be picked up in the Procurement Compliance Report Agenda item 2.2.1. **07/2022 5.2.0 Trust Assurance Framework** The part of this action to share BI requirements to support development of the TAF with Steve Wyndham has been completed but he is still awaiting confirmation and clarification of what support can be provided by the Audit Wales' Data Analytics Team. It was decided this action should remain open until feedback is received to say if work could be accommodated or not. Darren Griffiths agreed to feedback discussions to Steve Wyndham to provide an update via Lauren Fear. **10/2022 2.1.0 Procurement Compliance Report.** Matthew Bunce informed the Committee that Claire Bowden has been liaising with Welsh Government for clarification on the language and the meaning of the bullet points on Page 2 The process which NHS Wales bodies entering contracts with Welsh Government around the 10-day window of opportunity to question or challenge the contract before it gets put out onto the procurement portal. Welsh Government have responded saying the letter takes precedence and are going to provide this in writing. They confirmed they are not going to change the model Standing Order and Standing Financial Instructions until next year. ****ACTION: Following receipt of Welsh Government email informing the letter takes precedence, Matthew Bunce will produce a paper to go through Audit Committee saying the email forms part of our standing orders and standing financial instructions. To then be taken to the Board to get it ratified so everyone is very clear that the precedent is the letter and the notification, and not the table.**	**MB** **LF**

	10/2022 3.1.0 Trust Risk Register The Committee agreed this action could be **CLOSED**. New ****ACTION: Lauren Fear to follow up on action being progressed already for all Independent Members to have access to the Intranet.** **10/2022 3.2.0 Full Audit Action Tracker Review from Internal & External Audit** Agreed action could be **CLOSED** subject to amending the date stating when the email was sent to correspond with Agenda item 2.1.2 Chairs Urgent Action Report. **10/2022 5.2.0 Staff Wellbeing (Advisory)** Lauren Fear confirmed a conversation has taken place with Sarah Morley. This has been picked up with the Organisational and Development Team and isn't something that is currently reported through to Committees. Vicky Morris agreed this could be taken to the Private Quality and Safety Performance Committee, having a first report of that in the March 2023 and then including this in the Cycle of Business going forward. **10/2022 9.1.0 - Private Patient Service Debt Position** The Committee were happy with the update and that this would also 8.1.0 on the Agenda.	

	The AUDIT Committee **AGREED** and **NOTED** all the **CLOSED** actions.	
	Agenda item 8.1.0 Private Patient Service Debt Position was brought forward and discussed at this point in the meeting. See details in section 8.1.0 on the Agenda. The Committee NOTED the Private Patient Service Debt Position Report.	
2.0.0	**CONSENT AGENDA** Led by Martin Veale, Chair, and Independent Member	
2.1.0	**FOR APPROVAL** Led by Martin Veale, Chair, and Independent Member	
2.1.1	**Draft Minutes from the Public Audit Committee meeting held on 04 October 2022** Led by Martin Veale, Chair, and Independent Member The AUDIT Committee **AGREED** the minutes of the meeting held on the 04 October 2022.	
2.1.2	**Chairs Urgent Action Report** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff • Audit Action Tracker Requested Extension Date • Change to the 2022/23 Internal Audit Plan The AUDIT Committee **CONSIDERED** and **RATIFIED** the Chairs Urgent Action Report.	
2.1.3	**Velindre Counter Fraud Policy** Led by Gareth Lavington, Lead Local Counter Fraud Specialist The Committee reviewed and discussed the Velindre Counter Fraud Policy. Concerns were raised in relation to flow chart (Chart 1), as there appeared to be three routes to raise concerns. Gareth Lavington confirmed there is no stated preferred route as they try not to put people off. The preferred route would be to go straight to Gareth Lavington or Matthew Bunce but want people to have multiple access points to give options. Gareth Lavington highlighted that Communications go out to the organisation where all options are supplied but the preferred route is mentioned. Workshops are also held and posters are displayed so people know who to contract, so this is not just held within the policy. ****ACTION: Cover Report, section 3. IMPACT ASSESSMENT – EQUALITY IMPACT ASSESSMENT COMPLETED – Needs to be amended to state the Integrated Impact Assessment has been completed, been to Executive Management Board and submitted to the Equality Impact Assessment Group prior to submission to Audit Committee for approval. Once amended to be circulated to Audit Committee members with a copy of the Equality Impact Assessment.** ****ACTION: The Committee requested the following changes are made to the policy:** • **The name and Cardiff and Vale to be removed from the footnote.** • **Wording to be amended in Paragraph 2.1 The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of *a suspect* to be changed to The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of *an individual*.** The AUDIT Committee **APPROVED** the policy subject to amendments.	**AH** **GL**
2.1.4	**Amendment to Standing Orders - Schedule 3** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The AUDIT Committee **ENDORSED** for BOARD APPROVAL the amendments to the Trust Board Standing Orders – Schedule 3 as outlined in section 3 of this report and included in Appendix 1 & 2.	

2.2.0	**FOR NOTING** Led by Martin Veale, Chair, and Independent Member	
2.2.1	**Procurement Compliance Report** Led by Matthew Bunce, Executive Director of Finance Following a query relating to the recovery of records in storage damaged by flooding, Single Tender Action for storage of patient records, Matthew Bunce highlighted this was a specialist provider procured in an emergency and was all done according to regulations. Matthew Bunce assured the Committee on the steps being put in place following the incident: There is a strategy we are developing around records management, involving digitalisation of records as one priority, which is being incorporated as part of the Full Business Case plan of new hospital, as the design of that hospital does not have a medical records library built into the footprint. Velindre Cancer Centre currently has a hard paper library for ongoing care records and offsite storage for records of patients that are no longer on active treatment or are deceased. The strategy and the business case and the priority through the Integrated Medium Term Plan (IMTP) in terms of investment of digitalisation should start to reduce what's in hard storage offsite. Matthew Bunce confirmed a Lessons Learned Paper has already been completed internally as part of a working group which will then feed into some of this work in terms of the strategy. ****ACTION: Matthew Bunce to circulate the Lessons Learned Paper produced following the offsite storage incident to members out of Committee.** Following a query in reference to Betsi Cadwaladr managing the Welsh Blood Service procurement portfolio, Matthew Bunce advised the Committee that approximately a year and a half ago Jonathan Irvine, Director of Procurement and Shared Services put forward a new operating model to merge local and national teams and create teams that would learn and understand how to do the local and national procurement so there would be knowledge in those teams to do both. As Welsh Blood Service is very specialist the team across Wales focussing on the Laboratory kit is Betsi Cadwaladr. Helen James is part of Cardiff team supporting Velindre Cancer Centre. Matthew Bunce assured this has worked well and Betsi have lots of knowledge around the blood service. Cath O'Brien assured the Committee that she is impressed around the proactive approach from Betsi Cadwaladr and any concerns she had initially have been appeased. In relation to the All-Wales Contract Document Type 'Briefing', Matthew Bunce explained that a ratification paper is a paper that goes to the responsible director to sign off to say they are happy with the procurement route; a briefing is more for information and doesn't need sign off, so is part of the approval process and different routes. ****ACTION: Matthew Bunce to speak to Helen James to confirm to the Committee the term 'Briefing', from the All-Wales Contract, Document Type.** Vicky Morris raised concern on the non-compliant arrangements and a few are first submissions of non-compliance and the fact it doesn't say if there's a trend or a theme in terms of is it a team or individuals and the analysis of that needs to be shown and the procurement process should be followed, especially evident in relation to the Rugby World Cup item. ****ACTION Matthew Bunce will pick up with Helen James and ask her to agree an approach to do a more detailed review trend analysis and training in the areas of non-compliance.** Following discussion Matthew Bunce advised the Committee that any future concerns or issues, such as the size of the All-Wales Contract, could be raised at the Shared Services Audit Committee. The AUDIT Committee **NOTED** the report.	**MB** **MB** **MB**

2.2.2	**All Wales Audit Committee Chairs AWACC Meeting Highlight Report** Led by Martin Veale, Chair of the Audit Committee The Committee **NOTED** the information provided in this report.	
3.0.0	**PRIVATE PATIENT SERVICE REVIEW** Led by Matthew Bunce, Executive Director of Finance	
	Matthew Bunce highlighted the key aspects of the Private Patient Service Review: • Quality Safety and Performance is the lead in terms of oversight of the whole Action Improvement Plan. Audit Committee has been given responsibility by the Trust Board for the finance and commercial aspects. • Went through a procurement process and recognised we haven't got the expertise currently or the resource, so have brought in some support who are working well with the team and are focussing on commercial aspects. • Started to look at Tariff areas in which they have the knowledge and data bank of prices charged in other NHS private cancer services. They are also doing work around the debt process and how we collect income. • In relation to the Private Patient Management System, the advisors and the Private Patient Working Groups view is that we have all the systems there but need to identify the private patients and get all the information into one place. • In relation to negotiations of the contracts, Liaison said they will do all the ground work with us by March 2023. Meetings during April to June 2023 to discuss renegotiating the contracts, revised that date to the end of June 2023. Martin Veale raised some confusion over some revised target dates being marked non-applicable and the need to look at more realistic dates. Matthew Bunce realised that there was some confusion over the paper and this was not the most current version. There was also a question around if the paper would be on the next Quality Safety and Performance Agenda. The AUDIT Committee **NOTED** • Highlights from the Private Patient Improvement Group meeting December 2022. • Commencement of Liaison Financial Services external expert support for the areas identified in the improvement plan. The Audit Committee **APPROVED** the amended Private Patient Improvement Plan.	
4.0.0	**INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING**	
4.1.0	**Trust Risk Register** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear highlighted the following Key points to the Committee: • Further work completed on Velindre Cancer Centre risks. Ongoing discussions around the use of emails by the Medical Directorate around patient information. • Welsh Blood Service risks – Presentation at November 2022 Trust Board around some of the changes to the systems; the WHAIS (Welsh Histocompatibility & Immunogenetics Service). Had a review of the resulting risks because of those in development. Been through the Senior Management Team at Welsh Blood Service in December 2022 and January 2023. The Committee raised concerns around the following: • Number of risks at level 16 and whether there is enough detail to understand what is needed to be done to manage these risks? Should state what going to do and when. • Concern on the number of digital health and care record risks that are at level 16 that were sat at 16 previously. With the successful transfer of CANISC that should have reduced but there's no evidence in the paper or the risk register. • Not enough information currently to know what actions have been taken since the last report to mitigate the risks. Has there been any change in the score?	

	• In relation to the email risk, it's been on 427 days with no controls explicit in place and the progression being taken isn't reflected in the paper and needs to be included. • Needs to be clearer in the narrative what actions have been taken and therefore more columns are needed. • The Committee felt as the Quality Government Report highlights it doesn't give us the ability to scrutinise or gain assurance currently. • Outdated system risk appears in several places be helpful to pull them together so we can understand what the risk is and if it has been mitigated and the length of time the risk has been open and it would be helpful to what unit we are talking about, such as 72 days or 72 months? Need more information in this representation of the level 16 risks. Lauren Fear took the Committee through the key points of the Trust Risk Appetite: • Two key aspects for the Trust Board to approve, subject to endorsement from Audit Committee: - The level of risk appetite for each of the categories of risk. - The way in which the risk appetites levels translate into reporting through governance. • Appetite levels for different domains – The discussion at Board development focused on the workforce and environmental domains and the proposal consensus was to increase the appetite levels of those from two to three. • Levels of reporting into governance; proposal increase levels two and three to a 15 and four and five to a 16. • Did discuss in Board development and EMB if two and three at 15 was too low and whether there should be a 16 across those categories but decided not to take that step yet. Lauren Fear clarified that if a cautious appetite we would want a lower level of risk to be reported. Following confusion around the narrative Lauren Fear agreed rewrite the appetite statements from 2020 between now and Board to include new categories. Gareth Jones commented that having same escalation level for cautious and open doesn't seem right if there is a lower risk appetite? Lauren Fear responded to noting that they couldn't find another example of NHS Boards that have 12 rated risks reported on them and stated that it is far more common to have 16. 12 rated risks in cover paper only pull out 15 and 16. Most risk categories are cautious so if did reduce back to 12 would be very little change because of what doing now. Vicky Morris suggested these are taken to the Integrated Quality Governance Group, then be escalated to Quality Safety and Performance Committee, and then to Audit Committee. Noting these are also reviewed in Executive Management Board. ****ACTION: The AUDIT Committee agreed to review the format of Trust Risk Register Paper to include more details on the risks and their status and explicitly to say if there anything to escalate to Audit Committee or Quality Safety and Performance Committee of the discussions on the 12 and above's for the cautious categories from either Integrated Quality and Safety Group or Executive Management Board, this will involve setting up a small working group.**	**LF**
	The AUDIT Committee **NOTED** the risks level 16 and 15 reported in the Trust Risk Register and the on-going developments of the Trust's risk framework. The Audit Committee **ENDORSED** the revised Risk Appetite levels for Trust Board approval.	
	The AUDIT Committee took a break at 11:35AM and resumed the meeting at 11:45AM.	
4.2.0	**Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear provided a view across the risks in the TAF and the management of those risks and the review of the development for the framework noted the key points below:	

	• Discussed in the Board Development Session next steps for the further development and embedding of the TAF as a tool for managing strategic risks and how this is then embedded through the organisation. • Two reverse stress testing exercises are being undertaken for each division. Booked for February 2023 and will come through the March 2023 reporting cycle. The aim is to get that completed so that the Board can a have a review of the refresh of the risks themselves. • Need to agree where Audit Committee what to be in that process as won't be meeting in a standard way between now and then. Martin Veale felt this was a solid and detailed piece of work and was particularly pleased where we are identifying gaps where there's clearly an action to address the gaps, take assurance there are reviews of how our framework works. Vicky Morris encouraged Lauren Fear to ask Executive Directors in Quality Safety and Performance to talk to each of their elements because gaps are still identified in terms of second and third line of defence and it's varied across each of the TAF areas. Emma Rees assured the document is of good quality. Impressed with the work that's gone on and has been valuable when it comes to the planning process. Helps see gaps and controls and when the last time had assurance over those control, very clear and easy to follow. Gareth Jones raised the issue that where some of the actions where residual risk is 8 and hasn't changed since the date of the last review with a target risk of 6 but when look at action plan for assessing gaps, they are all complete so how do we get from the 8 to the 6? Lauren Fear recognised that something needs to be added to see what's changed from last time and what the impact was, a clearer view to get to target risk score. Darren Griffiths noted that through the Structured Assessment Reports its evident there's been development which has been positive in terms of the overall form of the TAF. There has been lots positive of discussions and the challenge is with the Trust using the TAF as a tool to drive forward improvements and to manage some of those strategic risks, moving away from the developments to the implementation and management for strategic risks. This area we will be reviewed on an ongoing basis through the structured assessment work. ****ACTION:** **-TAF 3 Draft People Strategy to be amended to note approved in May 2022.** **-TAF 6 says 25 inherent risks before now sitting at the risk of 15. Raise with Nicola Williams and then pick up in Quality Safety and Performance.** **Lauren Fear to review the template, to add context on what's changed from last time and what was the impact, to create a clearer view to get to target risk score.** **** ACTION: Clarity is needed around the target risk; if the target risk isn't reached should be actions that need to be done. If done all actions and not got to target rating then actions weren't complete. Lauren Fear to go back around the individual terms including where the same would apply for the control effectiveness rating and updated the template to be more specific.** The AUDIT Committee **DISCUSSED** and **REVIEWED**: • The progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework. • The update to the Trust Assurance Framework Dashboard.	**LF** **LF**
4.3.0	**Building our Future Together - Governance Assurance & Risk Programme of Work** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear took the Committee through the report and highlighted the following: • An organisational development programme built up of 11 workstreams. • The ongoing reporting of the workstreams will take place through Strategic Development Committee into Trust Board. • One of the programmes of work is governance assurance and risk.	

	• Have an informal group to continue and challenge and provide ongoing input into the various projects which has just started to meet with Gareth Jones as the Independent Member representative, and Nicola Williams as the Executive representative. • Trying to make sure the articulation of the outputs is clear on what can be achieved by Autumn 2023. Proposed that this plan is used to move from a maturity level of 4-5. Aim to complete this work in 2023 to move to 5 in the following financial year. Lauren Fear confirmed in relation to the blocking out of time this is due to aiming to leave time over summer early autumn to do the go back around testing. Gareth Jones noted the programme of work for this workstream is ambitious and reaches into most of what the Trust does, if get right will make the way the trust operates more effective and efficient. The Team initially did want it to be a longer period to achieve the objectives but this was pushed hard to get in 12-month period. The Committee agreed this be included on the Agenda at each Audit Committee to review progress. It pulls together TAF and Audit Action Tracker so will be a useful document going forward. ****ACTION: Table needs to be redrawn as not an accurate reflection of where we are currently. In relation to the document stating 11 of 20 streams are done, this needs to be corrected. Lauren Fear will recirculate.** The AUDIT Committee **DISCUSSED** the programmes of work and deliverables of the Governance, Assurance and Risk Programmes of Work and the timeline of the Governance, Assurance and Risk Programmes of Work, alongside the three year Building Our Future Together organisational change project. The AUDIT Committee **NOTED** the Terms of Reference for Governance, Assurance and Risk Programmes of Work Steering Committee.	**LF**
4.4.0	**Legislative & Regulatory Compliance Register** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The committee received the quarterly update and noted that the register was maturing well and is embedded through the various parts of the organisations governance process to get to this point to make sure we have the right input and review. Changes are referenced in section three. The Committee noted their thanks to Emma Stephens for the work that has gone into this. The AUDIT Committee **DISCUSSED** and **REVIEWED** and to examine any entries on the Register in full provided at Appendix one.	
4.5.0	**Audit Action Tracker Review of Recommendations from Internal & External - Overdue and Completed Recommendations** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce took the Committee through the report and highlighted the following: • Added timetable of all Committees that feed up and timescales when reviewing. • Trying to review monthly in EMB, feeding up to Audit Committee. • Following the Seven levels of assurance approach starting to be embedded across papers and action plans from this quarter, a pathway is needed for moving and implementing these. • Two new Internal Audit added since October Committee, with 11 recommendation and 14 actions. • Raised the question whether Audit Reports should be added to the tracker when signed off by Executive Leads and not wait for next the Committee. Matthew Bunce went through the red actions and the reasons for them having an overdue status: • Financial Systems 2021-22 Audit Report – BT invoices being paid late and overdue.	

	Evidenced in update columns been trying to resolve this issue. Action in place to remove ourselves completely from these BT charges. Capital funding has been allocated to support implementation of the SIP circuit with Digital colleagues, which will be in place through our capital programme in the next 7-8 months. The Committee agreed current extension 28 February 2022 (should read 2023) needs to change to August 2023 to allow for the 7 months extension. • Finance & Service Sustainability - Evidencing Budget Monitoring / Actions to Address Variances (Operation). Will have a meeting with the budget holder and an email will go out with the actions but this is what Internal Audit have flagged, to make that a more consistent approach, by having a proforma for each meeting that's standard, where you note down the date and time and who was present and list the actions to take away to improve variants where there are overspends and issues. The Committee agreed to an extension for another 6 months, until July 2023. ****ACTION: Typo on the table in the cover paper, 2.2.4 to be change to January '23 Audit Committee from January '22 Audit Committee.** The AUDIT Committee **NOTED** the contents of the report and the assurance it provides regarding the activities undertaken to address audit recommendations in response to audit report recommendations and associated risks. The AUDIT Committee **APPROVED** the Closure of the 11 Internal Audit report actions (20%) and six External Audit report actions (54.7%) completed since the October 2022 Audit Committee (Green Status) and agreed these actions could be formally closed (Blue Status), and the revised extension dates for the two Internal Audit report actions (4%) that have passed the agreed implementation date (Red Status).	**MB**
5.0.0	**EXTERNAL AUDIT** Led by Darren Griffiths (Audit Wales)	
	Audit Position Update Led by Darren Griffiths (Audit Wales) Darren Griffiths presented the Audit Position Statement around the current state of our audit work on the Trust and wished to draw attention to three pieces of work specifically: • On course to complete the 21/22 Charitable Funds Financial Statement by the end of January 2023, that work is in progress. • Issued the draft Structured Assessment Report for 2022 to the Trust for clearance. In discussions about the timescales for finalising the report and presenting it to Board. • Commenced Workforce Planning Review at the Trust. Hoping to report on that work in April or May 2023. Matthew Bunce confirmed that the Charitable Funds Trustee Annual Report was being audited today. The Report was anticipated to be ready for approval at the Charitable Funds Committee meeting in January 2023. Darren Griffiths updated the Committee that Claire James was not appointed on a substantive basis to the Director role, so interim cover has been arranged whilst a substantive appointment is made. Richard Harries is the director who will be overseeing financial audit work and David Thomas will be picking up the Engagement Director responsibilities. There will be some formal communications going out to the Trust over the next couple of weeks confirming these arrangements. Martin Veale requested that someone from Audit Wales Financial Accounting is present at the Committee when discussing accounts. Martin Veale queried the Financial Section paragraph 4, which stated that audit timings are still uncertain. He asked for clarity on when certainty was going to emerge. Darren Griffiths gave assurance that accounts audit colleagues are working through issues currently and hopefully can provide an update by the end of the month as to the likely impact on timescales and will inform the Trust as soon as confirmed.	

	Performance Audit: Darren Griffiths informed the Committee that Audit Wales is still in the process of identifying a suitable topic for local review. Darren Griffiths in response to Committee questions stated there is the option of rolling the 2022 fee into the 2023 fee and undertaking larger piece of local work, something we can explore with Lauren Fear as part of the planning work. The AUDIT Committee **NOTED** the Audit Position Update.	
5.2.0	**Review of VUNHST Quality Governance Arrangements and Management Response** Led by Darren Griffiths (Audit Wales) Darren Griffiths took the Committee through the report and highlighted the following: • Overall, the report found that significant progress has been made to improve the Trusts arrangements and made 6 recommendations. • The report already been considered by Quality Safety and Performance Committee. • The Structured Assessment Report will be updated to reflect the current position in relation to improvement identified in the review of Quality Governance Arrangements Report. Lauren Fear confirmed the survey was sent to staff across the organisation, there were several reminders and the survey was extended for a couple of weeks at the end. Responses need to be taken to EMB to get a clear response to that agreed and communicated through the organisation. The Committee were concerned with responses suggesting that the organisation is not always able to provide safe and effective care, and noted the need address this, including the need to cross reference both these issues in terms of where support or analysis needs to be undertaken. The Committee recognised there are several points in the report that Independent Members have been raising so it was important to be able to triangulate that. Quality Safety and Performance Committee will be the carefully tracking all the actions. The AUDIT Committee **NOTED** the report.	
5.3.0	**Equality Impact Assessments: more than a tick box exercise? and Management Response** Led by Darren Griffiths (Audit Wales) Darren informed the Committee this is a national report undertaken by Audit Wales national studies team which looked at the overall approach to undertaking the quality impact assessment in public bodies across Wales. Focussing primarily on understanding the approaches within Public Sector bodies with a view to finding good or interesting practice and identifying common areas for improvement. Martin Veale noted the good practice being helpful in terms of making sure our Equality Impact Assessments are completed properly and tying this into the Integrated Medium Term Plan. Lauren Fear stressed the importance of these report getting distributed to the people involved in developing Equality Impact Assessments. The AUDIT Committee **NOTED** the report.	
5.4.0	**The National Fraud Initiative in Wales 2020-21** Led by Darren Griffiths (Audit Wales) Darren Griffiths presented the interactive report which presents the findings of our bi-annual National Fraud Initiative exercise. Made several recommendations to all the bodies participating in the exercise. The Committee recognised this as a helpful national report and will keep an eye on it. The AUDIT Committee **NOTED** the report.	

6.0.0	**INTERNAL AUDIT** Led by Emma Rees, Audit Manager (NWSSP - Audit and Assurance Services)	
6.1.0	**2022/23 Internal Audit Progress Update Report** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees informed the Committee that the audit plan is progressing well this year. Key performance Indicators on management responses are still showing as red but that is not indicative of any underlying engagement issues during the audit at any level of the organisation. Working on a way to help collaborate and engage better so hopefully will start to see some improvements in that area. The AUDIT Committee **NOTED** the report.	
6.2.0	**Managing Attendance at Work** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) The AUDIT Committee **NOTED** the report, which gave a Reasonable assurance rating.	
6.3.0	**Patient & Donor Experience** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) The AUDIT Committee **NOTED** the report, which gave a Reasonable assurance rating	
6.4.0	**Digital Health & Care Record – Implementation** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) The AUDIT Committee **NOTED** the report, which gave a Substantial assurance rating.	
6.5.0	**Decarbonisation All-Wales report (Advisory)** Led by Paul Stocker, Internal Audit Manager (NWSSP - Audit and Assurance Services) Paul Stocker informed the Committee that there was some initial work at several health bodies at a national level at an early stage of development so decided an advisory review would be undertaken whilst recognising share best practice across NHS bodies to reduce carbon emissions in line with government requirements. Ensured Velindre has sufficient responses to carry out the decarbonisation activities, having a detailed funding strategy in place for implementing the decarbonisation action plan. The AUDIT Committee **NOTED** the report.	
6.6.0	**Performance Management Framework** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) The AUDIT Committee **NOTED** the report, which gave a Reasonable assurance report.	
6.7.0	**nVCC Contract Management Report** Led by Felicity Quance, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Felicity Quance highlighted the following Key points to the Committee: • The Limited assurance rating given to this report is based on noncompliance with Standing Financial Instructions and Standing Orders, approval of contracts, and variation in contract documentation not being in place in a timely manner. • Acknowledged there have been various challenges facing the project with procurement and the technical advisory services and some of the requirements have had short timeframes, therefore the governance framework in place hasn't necessarily allowed that to be implemented in advance. • One matter arising with three high rated recommendations. • In relation to development of a contract management framework, Internal Audit haven't seen the framework to be able to confirm that it meets all the requirements., will be something picked up as continue through the ongoing work, hence why the implementation date has been noted as ongoing.	

	• Got the approved integrated audit plan which incorporated an element of procurement which can cover several areas? Are going to be doing a specific piece on the procurement that will lead up to the competitive dialogue and the preferred bidder. Were asked by Mark Ash to investigate the contract management process as he had concerns based on a report being presented to seek retrospective approval, which was challenged and additional work was required. There was collective concern throughout the Committee that the agreed target management responses need to address these weaknesses as soon as possible which can lead to a follow up report where we hopefully get an improved assurance rating. The committee felt that the report needed a better action plan than the one that's been presented today. Transforming Cancer Services Scrutiny Committee and Board have discussed these issues have been concerned and Independent Members are seeking more information that's identified in the report with more robust management responses. ****ACTION: Felicity Quance and Matthew Bunce will correspond and pick up with Mark Ash to update the action plan and management responses. The updated audit report will then be sent to Transforming Cancer Services Scrutiny.** Matthew Bunce confirmed he is working on a Lessons Learned paper in relation to these issues, which is in draft with Martin Veale currently. ****ACTION: Review OF TCS Enabling Works Professional Services Contract Commitments Made Without Prior Board Approval Lesson Learned Paper to be brought to the next Audit Committee.** The AUDIT Committee **NOTED** the report subject to the discussed changes.	**MB** **MB**
7.0.0	**COUNTER FRAUD**	
7.1.0	**Counter Fraud Progress Report Quarter 3** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Lavington highlighted the following Key points to the Committee: • On course with days provision for the year. • New staff member started in January 2023, so now have a full complement. • Haven't had any new referrals. • Going to be running a Fraud Awareness Week where there will be some pop-up stalls and awareness talks for the organisation. • Within the appendices, the fraud risk profile letter that has now been completed been drawn from the Counter Fraud Authority inherent risks to organisations and it's been shortlisted regarding those risks that we believe are specific to Velindre. • There has been a report commissioned by Shared Services Partnership in relation to the Counter Fraud arrangements across NHS Wales, being discuss at Director of Finance level. ****ACTION: Gareth Lavington agreed to make sure people are aware of the new policy in place on any Communication and will include on the newsletter.** The AUDIT Committee **RECEIVED** and **DISCUSSED** the report.	**GL**
8.0.0	**FINANCE**	
8.1.0	**Private Patient Service Debt Position** Led by Rachel Hennessy, Interim Director of Velindre Cancer Centre Rachel Hennessy highlighted the following key points to the Committee: • Working closely with the team from Liaison to put structure around Private Patient Service. • August 2022 billing not accurate due to challenges, only in the process this week of being able to finalise. • August, September, and October 2022 are only partly billed because there are issues with the Chemotherapy Care Report but that will be fully billed by the 31st of January 2023.	

	November, December, and January will then be billed by the end of February 2023, which means going forward will be within the 30-day billing from March 2023 onwards. • Private Patient team in process of fully reviewing the aged debt to be completed by end of January 2023, provided they can get all the active debt collection information. • Have noted there is an anomaly around September 2022 doing exploration around that to understand the rationale behind that change in pattern. Gareth Jones questioned the Key Performance Indicators and targets to be agreed, which seem to be a historic snapshot of where we were and there needed to be more clarity on 'how are we aiming to bring these down and by percentage over the next few months?' Rachel Hennessy responded that the team are working with Liaison to review all the Key Performance Indicators using their experience working with other organisations outside Velindre in terms of what is normal for Key Performance Indicators when managing Private Patient Services. Agreed concerns can be feedback to ensure these are looked at in context. Claire Bowden highlighted that these sorts of Key Performance Indicators were informed by the Internal Audit review. It was recognised at the time they weren't necessarily perfect and the comment was around general debts being measured in that way rather than specifically the Private Patient Service but agreed these could be changed to be more reportable and relevant. Matthew Bunce agreed these are just performance but you haven't got the targets. Going forwards targets will be set based on the good work and intelligence and knowledge of Liaison and bring back to the Audit Committee to see if seem reasonable, to give some assurance and then this will be monitored. Vicky Morris questioned Section 2.6 noting the targets are yet to be agreed, the September 180.5% and a minus 46% and wasn't clear why ended up with 180.5%? Claire Bowden responded clarifying that in July 2022 no debts were raised and a significant exercise happened in August 2022 to catch up, and as a lot of those were paid it skewed September 2022 figures. The billing currently hasn't been consistent, ups and downs won't be seen when billing and collecting debts on a timely basis. Matthew Bunce highlighted the need to reconsider how the table is being presented and the layout of the paper. ****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.** The AUDIT Committee **REVIEWED** the financial key performance indicators there were in the paper currently but took a way the additional action to develop the report as indicated.	**RH**
8.2.0	**Receipt of Finance Technical Updates** Led by Claire Bowden, Head of Financial Operations Claire Bowden informed the Committee that a new International Financial Reporting Standard (IFRS 16) for leases will be applicable to the Trust's financial statements this year. This is likely to be an area of focus for Audit colleagues given it's the first year the standard is being adopted, and there will be some additional disclosures in the financial statements in this respect. Finance staff across the Trust have completed preparatory work and engaged with finance colleagues across NHS Wales and within Welsh Government. In response to a query, Claire Bowden assured the Committee an asset verification exercise is completed every year. The AUDIT Committee **REVIEWED** and **NOTED** the report.	
8.3.0	**Losses and Special Payments Report (Verbal Update)** Led by Claire Bowden, Head of Financial Operations Clare Bowden informed the Committee there was nothing to report in relation to losses and special payments.	

9.0.0	**ADMINISTRATION**	
9.1.0	**Production of Audit Committee Annual Report** Led by Claire Bowden, Head of Financial Operations and Martin Veale, Chair of the Audit Committee The AUDIT Committee **APPROVED** the report prior to submission to Trust Board for noting.	
9.2.0	**Review of Audit Committee Terms of Reference** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff The AUDIT Committee **REVIEWED** the Audit Committee Terms of Reference and **APPROVED** the Audit Committee Terms of Reference, with no suggested changes to be applied.	
10.0.0	**HIGHLIGHT REPORT TO THE TRUST BOARD**	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared in readiness for its meeting 31 March 2023. No points for escalation.	
11.0.0	**MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS**	
	Discussions on extra meeting toward end of March 2023 to be held out of Committee.	
12.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	None.	
13.0.0	**DATE AND TIME OF NEXT MEETING**	
	Tuesday 25 April 2023 at 10:00AM..	
14.0.0	**CLOSE**	
	The meeting CLOSED at 1:15PM.	

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 03 May 2022 Meeting			
05/2022 6.6.0	**Internal Audit Report: DBS Checks** In relation to Management response 2.1.a. (i) DBS Policy target date of September 2022 is too far away. ****ACTION: Matthew Bunce to feedback to Sarah Morley that the Trust should develop it's DBS Local Policy as a matter of priority and consider the points raised in the recommendations/findings.**	**ACTION: Sarah Morley**	**CLOSED** **Update March 2023:** This action has been completed. The policy and supporting documents were approved in January 2023 and are available on the Trust intranet. For further information please refer to the Audit Action Tracker DBS Check 2021/22 Audit Report section. **Update DECEMBER 2022:** The draft DBS procedure is Has been shared with TU colleagues and Safeguarding group for comment. This is to be shared with EMB in January 2023 for approval. **Update SEPTEMBER 2022:** The draft DBS procedure is currently with Trade Union colleagues for comment as all documents are developed in Partnership. Comments requested back by 7th October. Two	**SM**

			responses received so far. Once this has been collated and amendments made this will be progressed to SLT/SMT for comment and then to EMB for approval. **OPEN** **Update JULY 2022:** DBS Policy is on track to be developed by September 2022. The policy has to go through its internal consultation phase and be signed off. It is not possible to do this within any shorter timeframe. The Trust currently has a clear procedure for the use of DBS Checks which is being followed for all appointments.	
	Actions from 19 July 2022 Meeting			
07/2022 2.2.1	**Procurement Compliance Report** Andy Butler (AB) has provided MB with an update that a protocol is being developed by NWSSP to give the Trust Audit Committee, through the Director of Finance, early sight of any risk of legal challenges from bidders participating in All Wales Contract tenders**.** **ACTION: Draft protocol to provide Trust Audit Committee with early sight of any risk of legal challenge from bidders participating in All Wales Contract tenders**	**ACTION: Andy Butler and Matthew Bunce**	**CLOSED** **Update APRIL 2023:** Meeting held 08 February 2023 with Gareth Jones, Vicky Morris, Matthew Bunce, Jonathan Irvine, and Andy Butler. Jonathan Irvine has amended Point 5 to take account a discussion in relation to the decision as to whether to award a contract after it has	**AB / MB**

	to be included in October 2022 Audit Committee.		received a challenge or potential challenge from a disgruntled bidder and the fact that the Trust is notified afterwards. **Update DECEMBER 2022:** GJ fed back to MB that he still had concerns and wanted further discussion with NWSSP on this matter. MB raised GJ concerns with AB who agreed to arrange further meeting between LF, MB, GJ, AB and JI. Meeting arranged 08 February 2023 with MB, LF, GJ, MV, AB and JI. **Update SEPTEMBER 2022:** NWSSP Director of Procurement has shared draft protocol for consideration by the Trust. Meeting arranged 28 September 2022, between Trust DOF, NWSSP DOF and NWSSP Director of Procurement. The draft protocol was shared outside of Committee with MV and GJ for review.	

07/2022 2.2.1	**Procurement Compliance Report** Initial assessment by the new Head of Procurement is that there are a high volume of Single Tender Actions (STAs) and Single Quotation Actions (SQAs) for which potentially alternative complaint procurement routes may be available. Procurement will commence work to review all available procurement framework agreements to establish whether they can be accessed as an alternative route to market, negating the need for SQA/STA. ****ACTION: Head of Procurement to provide an update and circulate an update ahead of next Audit Committee.**	**ACTION: Helen James**	**OPEN** **Update APRIL 2023:** Work is ongoing within the VEL/NWSSP procurement team to convert SQA/STA's to a multiquote/Framework Agreement/open competition to test value for money, ensure compliance and good procurement practice. Training and workshops will be delivered from April 2023 to update and engage with stakeholders in this change of practice. **Update SEPTEMBER 2022:** Included in the Procurement Compliance Report on agenda. The process to review alternative procurement routes has commenced, but this will take approximately 6 months to complete.	**HJ**
07/2022 5.2.0	**Trust Assurance Framework** ****ACTION: Emma Stephens to discuss with Lauren Fear our requirements for Power BI to support further future development of TAF and share with Steve Wyndham to assess feasibility of what support might be available from Audit Wales Data Analytics Team to take forward as a project.**	**ACTION: Emma Stephens**	**OPEN** **Update APRIL 2023:** The Digital Team are now supporting the BI work around the TAF. Work has been developing for a couple of months and a follow up meeting is planned for 20.04.2023 when we expect to have a	**ES**

			first draft of the TAF BI product. **Update JANUARY 2023:** BI requirements to support development of the TAF have been shared with Steve Wyndham, Audit Wales. Awaiting confirmation and clarification of what support can be provided by Data Analytics Team within Audit Wales. In addition, discussions have been held with Head of Digital Delivery to explore any resource that is available internally. There is scope for limited resource to support in next few months, pending completion of Audit Tracker support that is being prioritised. **Update SEPTEMBER 2022:** Scope of BI support requirements currently being assessed in conjunction with Trust Digital Services to assess possible support to be requested from Audit Wales. This will be confirmed before end October 2022.	

	Actions from 04 October 2022 Meeting			
10/2022 2.1.0 **01/2023 1.4.0**	**Procurement Compliance Report** ****ACTION: Matthew Bunce to confirm the language and the meaning of the bullet points on Page 2 *The process which NHS Wales bodies entering into contracts* with Welsh Government.** ***Further Action following 12 January 2023 Audit Committee listed below.***	**ACTION: Matthew Bunce**	**CLOSED** **Update April 2023:** The points highlight the WG Policy requirement for all NHS contract over £1m, to be approved by the DGHSS prior to award, and any contracts awarded over £500k to be noted by the DGHSS. (there are certain exemptions to this i.e contracts of employment, inter NHS orgs) **Update JANUARY 2023:** Seeking clarification from Welsh Government colleagues.	**MB**
10/2022 9.1.0	**Private Patient Service Debt Position** ****ACTION: Lisa Miller responded that no assessments have been completed on recovery in the last 6 months and will action this, working closely with Claire Bowden.**	**ACTION:** ~~Lisa Miller~~ **Rachel Hennessy / Ann Marie Stockdale**	**CLOSED** **Update APRIL 2023:** External company LIASION supporting. **Update DECEMBER 2022:** Assessment currently underway which will presented to Director of Finance during quarter 4 of 2022/23.	~~**LM**~~ **RH / AMS**

	Actions from 12 January 2022 Meeting			
01/2022 1.4.0	**Procurement Compliance Report** ***Further Action following 12 January 2023 Audit Committee listed below.*** ****ACTION: Following receipt of Welsh Government email informing the letter takes precedence, Matthew Bunce will produce a paper to go through Audit Committee saying the email forms part of our standing orders and standing financial instructions. To then be taken to the Board to get it ratified so everyone is very clear that the precedent is the letter and the notification, and not the table.**	**ACTION: Matthew Bunce**	**OPEN** **Update APRIL 2023:** Matthew Bunce has been liaising with Welsh Government but the response received did not deal with the inconsistency between the table of delegated limits in Standing Orders / Standing Financial Instructions and the letter. Further information will be requested.	**MB**
01/2023 1.4.0	**Action Log - Trust Risk Register** ****ACTION: Lauren Fear to follow up on action being progressed already for all Independent Members to have access to the Intranet.**	**ACTION: Lauren Fear**	**CLOSED** **Update APRIL 2022:** Individual calls were logged with Digital for each of the Independent Members and Digital completed the set up each for each Independent Members to access the Intranet using the Microsoft Authenticator at the end of November 2022. The Independent Members were each subsequently sent instructions from Digital to set up the Microsoft Authenticator and provided with a guideline document to follow for the set up.	**LF**
01/2023 2.1.3	**Velindre Counter Fraud Policy** ****ACTION: Cover Report, section 3. IMPACT ASSESSMENT – EQUALITY IMPACT ASSESSMENT COMPLETED – Needs to be amended to state the Integrated Impact Assessment has been completed, been to Executive Management**	**ACTION: Alison Hedges**	**CLOSED** **Update FEBRUARY 2023:** The Updated Policy, Updated Front Cover Sheet and copy of the Equality Impact Assessment were circulated to Audit	**AH**

	Board and submitted to the Equality Impact Assessment Group prior to submission to Audit Committee for approval. Once amended to be circulated to Audit Committee members with a copy of the Equality Impact Assessment.		Committee Members 06/02/2023.	
01/2023 2.1.3	**Velindre Counter Fraud Policy** **ACTION: The Committee requested the following changes are made to the policy:** • **The name and Cardiff and Vale to be removed from the footnote.** • **Wording to be amended in Paragraph 2.1 The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of *a suspect* to be changed to The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of *an individual*.**	**ACTION: Gareth Lavington**	**CLOSED** **Update JANUARY 2023:** The Policy has been updated to reflect these requested changes.	**GL**
01/2023 2.2.1	**Procurement Compliance Report** **ACTION: Matthew Bunce to circulate the Lessons Learned Paper produced following the offsite storage incident to members out of Committee.**	**ACTION: Mathew Bunce**	**CLOSED** **Update APRIL 2023:** The Off-Site Storage Incident Lessons Learned Paper was circulated to the Audit Committee members 13/04.2023.	**MB**
01/2023 2.2.1	**Procurement Compliance Report** **ACTION: Matthew Bunce to speak to Helen James to confirm to the Committee the**	**ACTION: Mathew Bunce**	**CLOSED** **Update APRIL 2023:**	**MB**

	term 'Briefing', from the All-Wales Contract, Document Type.		This means that a Briefing paper is produced for approval prior to any procurement process commencing. It provides a background of the market, the procurement route, and potential values of the intended contract	
01/2023 2.2.1	**Procurement Compliance Report** **ACTION Matthew Bunce will pick up with Helen and ask her to agree an approach to do a more detailed review trend analysis and training in the areas of non-compliance**	**ACTION: Mathew Bunce**	**OPEN** **Update APRIL 2023:** Best practice report will be adopted for the next meeting that details the trend analysis which captures the "hot spots", where further training is required.	**MB**
01/2023 4.1.0	**Trust Risk Register** **ACTION: The AUDIT Committee agreed to review the format of Trust Risk Register Paper to include more details on the risks and their status and explicitly say is there anything to escalate to Audit Committee or Quality Safety and Performance Committee of the discussions on the 12 and above's for the cautious categories from either Integrated Quality and Safety Group or Executive Management Board, this will involve setting up a small working group.**	**ACTION: Lauren Fear**	**CLOSED** **Update APRIL 2023:** Risk Register template has been updated following review with Independent Members who sit on the Audit Committee. The new template includes additional information. Specific risks will be highlight as and when they need to be escalated to relevant committees.	**LF**
01/2023 4.2.0	**Trust Assurance Framework** **ACTION:** **-TAF 3 Draft People Strategy to be amended to note approved in May 2022.**	**ACTION: Lauren Fear**	**CLOSED** **Update APRIL 2023:** Taf 3 - has been amended as per the action.	**LF**

	-TAF 6 says 25 inherent risks before now sitting at the risk of 15. Raise with Nicola Williams and then pick up in Quality Safety and Performance. **Lauren Fear to review the template, to add context on what's changed from last time and what was the impact, to create a clearer view to get to target risk score.**		TAF 6 – Risk is regularly reviewed by Nicola Williams as part of the review cycle of the TAF. TAF risks relevant to the Quality, Safety and Performance Committee are reported. Template has been reviewed with additions made to the include more visibility of impact of actions on risks.	
01/2023 4.2.0	**Trust Assurance Framework** **ACTION: Clarity is needed around the target risk; if the target risk isn't reached should be actions that need to be done. If done all actions and not got to target rating then actions weren't complete. Lauren Fear to go back around the individual terms including where the same would apply for the control effectiveness rating and update the template to be more specific.**	**ACTION: Lauren Fear**	**CLOSED** **Update APRIL 2023:** The launch of the new template has a stronger emphasis on actions, including the impact on risk levels. In addition, the ongoing review will include stringent review of actions to the point where an action becomes a control.	**LF**
01/2023 4.3.0	**Building our Future Together - Governance Assurance & Risk Programme of Work** **ACTION: Table needs to be redrawn as not an accurate reflection of where we are currently. In relation to the document stating 11 of 20 streams are done, this needs to be corrected. Lauren Fear will recirculate.**	**ACTION: Lauren Fear**	**CLOSED** **Update APRIL 2023:** The timeline for the Governance , Assurance and Risk programme of work has been reviewed and revised with clearer articulation of current positions and progress.	**LF**
01/2023 4.5.0	**Audit Action Tracker Review of Recommendations from Internal & External - Overdue and Completed Recommendations**	**ACTION: Matthew Bunce**	**CLOSED** **Update January 2023:** The changes have been made to the Cover Paper.	**MB**

	ACTION: Typo on the table in the cover paper, 2.2.4 to be change to January '23 Audit Committee from January '22 Audit Committee.			
01/2023 6.7.0	**nVCC Contract Management Report ACTION: Felicity Quance and Matthew Bunce will correspond and pick up with Mark Ash to update the action plan and management responses. The updated audit report will then be sent to Transforming Cancer Services Scrutiny.**	**ACTION: Matthew Bunce**	**CLOSED** This will be picked up as part of the Review Report on the April 2023 Audit Committee Agenda.	**MB**
01/2023 6.7.0	**nVCC Contract Management Report ACTION: Review OF TCS Enabling Works Professional Services Contract Commitments Made Without Prior Board Approval Lesson Learned Paper to be brought to the next Audit Committee.**	**ACTION: Matthew Bunce**	**CLOSED** This will be picked up as part of the Review Report on the April 2023 Audit Committee Agenda.	**MB**
01/2023 7.1.0	**Counter Fraud Progress Report Quarter 3 ACTION: Gareth Lavington agreed to make sure people are aware of the new policy in place on any Communication and will include on the newsletter.**	**ACTION: Gareth Lavington**	**CLOSED** **Update MARCH 2023:** Requested to be published internally for staff on the Staff Communications and Finance Share point pages. Included in the newsletter.	**GL**
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**	**OPEN** **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**

AUDIT COMMITTEE

Private Patient Service Improvements

DATE OF MEETING	25th April 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance
REPORT PURPOSE	FOR DISCUSSION AND APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Private Patient Improvement Group	23/02/2023	Approved content
EMB	TBC	Endorsed

ACRONYMS	
VUNHST	Velindre University NHS Trust
EMB	Executive Management Board

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

1. PURPOSE

This paper is for the Audit Committee to:

- **NOTE** the highlights from the Private Patient Improvement Group meeting held during February 2023.
- **APPROVE** the amended Private Patient Improvement Plan
- **NOTE** the continuance of Liaison Financial Services external expert support for the areas identified in the improvement plan

2. BACKGROUND

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

3. REPORTING COMMITTEES

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

4. PRIVATE PATIENT IMPROVEMENT HIGHLIGHT REPORT

The following are highlights from the Private Patient Improvement Group meetings held between December 2022 and February 2023 meetings:

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

	remain for the preparation work of reviewing current contracts, tariffs and ensuring Trust billing is up to date. ➢ Develop new professional fee arrangements which provide consistency across disciplines ➢ Develop a private patient tariff for both self-pay and insured private patients ssetting fees at commercial levels – **Liaison *work has commenced to review the current fees and cost of services which will then be compared to market intelligence around fees for cancer services in other NHS Private Patient services*** ➢ Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure. ➢ Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act. ➢ Increase private income through exploiting opportunities to expand the clinical scope of the private patient service. ➢ Procure or develop a private patient management system that will enable production of regular management information including a private patient activity report - ***PPMG agreed that current Trust systems appropriate to capture information.*** ➢ Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk. ➢ Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service. ➢ Retrospective review of last 2 years insurer income to identify if Trust can recover additional income for services provided – ***Liaison commenced work reviewing income and patient data provided by Trust*** ➢ The review of current service provision and negotiations with insurers by Liaison has resulted in further income generation at an indicative £50k per annum, with the potential to increase.
ASSURE	• Monthly meetings established of the improvement group with terms of reference approved that clearly articulates the task and finish nature of the group, the required attendee and their roles/responsibilities • A Project Manager and admin support is being provided to the private patient project • The aged debt profile and risk have been reduced significantly in comparison to the baseline audit reference period, which is reflected in regular reporting to the Audit Committee. • Good progress has been made on the operational actions which includes a review and update of Standard Operating Procedures, a review of pre-authorisation and invoicing processes.

	• Clear demarcation between the Improvement and Delivery Groups.
INFORM	There were no matters to Inform
APPENDICES	***1. Private Patient Improvement Plan***

5. IMPACT ASSESSMENT

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

6. RECOMMENDATION

The Audit Committee is asked to:

- **NOTE** the highlights from the Private Patient Improvement Group meeting held during December 2022 and February 2023 periods.
- **APPROVE** the amended Private Patient Improvement Plan and **AGREE** to oversee the implementation of the financial and commercial improvements
- **NOTE** the progress of Liaison Financial Services external expert support for the areas identified in the improvement plan

Improvement Plan - Private Patient Service

Date Updated: 18/04/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
STRATEGIC BUSINESS MANAGEMENT									
PP1	**CLOSED**	28.01.22	Review and update Private Patient Service Specification	Quality, Safety & Performance	21/11/22 - Draft Policy circulated to Improvement Group members on 12th and 19th November 2022. Awaiting feedback. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Executive Team decided that current sevice provision is to be maximised but not expanded upon at present, current service specification reflects this.**	Head of Operational Services and Delivery	30/06/2022	31/03/2023	Determined that existing strategy and range of services offered should remain as currently offered whilst the improvements are implemented
PP16	**CLOSED**	28.01.22	Develop marketing plan/commercial strategy	Quality, Safety & Performance	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - As private patient offer has not changed, marketing materials refreshed but no expanded service marketing/commercial plan.**	COB/MB / External Provider	31/07/2022	31/03/2023	Determined that existing strategy and range of services offered should remain as currently offered whilst the improvements are implemented. Marketing materials refreshed, but no new marketing channels proposed during stabalisation of service
PP3	**CLOSED**	28.01.22	Integrate business planning into Trust IMTP process	Quality, Safety & Performance	The service management group feeds into the wider Operational Services and Delivery Directorate where such business planning takes place. This feeds into the IMTP process. Content for 2023/24 IMTP will be based on outcome of strategy discussions and direction.	AMS	31/07/2022	N/A	Private Pateint Strategy and direction refelcted in IMTP
PP19	**IN PROGRESS**	28.01.22	Develop a new private patient pack, brochure, and stationery to be sent to all private patients prior to their admission/outpatient appointment and for marketing purposes.	Quality, Safety & Performance	Links to Strategy. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - existing materials being refreshed based on retention of current service offer.	External provider	30/09/2022	30/04/2023	
PP5	**IN PROGRESS**	28.01.22	Develop/procure and implement patient management and information system	Quality, Safety & Performance	Electronic patient record in place. The Digital Health and Care Record will be implemented across the Private Patient Service. Standard reports agreed with the Business Intelligence Team.	AMS	31/07/2022	N/A	
PP26	**IN PROGRESS**	28.01.22	Develop and implement a marketing plan and processes for both traditional and on-line digital	Quality, Safety & Performance	This will follow the agreement of a Strategy.			30/04/2023	Refer to Action PP19
PP8	**IN PROGRESS**	28.01.22	Produce job planning guidance to define NHS and private patient work within Consultant job plans	Quality, Safety & Performance	National template used which is incorporated into job planning discussions.	EGE/NH	30/04/2022	N/A	
PP9	**IN PROGRESS**	28.01.22	Implement changes to the existing clinical governance arrangements which provide assurance that private patient work is subject, as a minimum, to the same scrutiny and level of service for NHS patients.	Quality, Safety & Performance	Common systems, policies and procedures used for NHS and private patients to collect clinical information, risks, incidents, complaints and claims. Patients can be idenfied by certain fields.These are monitored at a monthly management group. Information is included in indivdiaul apprasials as part of the standard process.	JA	30/04/2022	N/A	
PP10	**IN PROGRESS**	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Quality, Safety & Performance	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action.	EGE/AMS	30/06/2022	30/06/2023	
PP12	**IN PROGRESS**	28.01.22	Introduce private patient contract/agreement to be signed by all staff undertaking PP practice.	Quality, Safety & Performance	Process in place for Consultants who undertake private practice. 18/04/23 - awaiting establishment of Medical Advisory Committee, to advise and enfore practice	EGE/AMS	31/07/2022	30/06/2023	

Improvement Plan - Private Patient Service

Date Updated: 18/04/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
PP13	**CLOSED**	28.01.22	Ensure rolling programme in place to ensure workforce agreements are reviewed in a timely manner	Quality, Safety & Performance	Cycle of business in place for the service and under development for management group.	AMS	30/04/2022	N/A	Cycle of business in place for the service to review workforce agreements regarding PP work
PP17	**IN PROGRESS**	28.01.22	Renegotiate the contracts with large insurers	Audit Committee	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December 2022. 21/12/2022 - Target date revised to reflect discusions with Liaison Services who are supporting the renegotiation. A target of 31/03/2023 will remain for the preparation work of reviewing current contracts, tarrifs and ensuring Trust billing is up to date. DPIA's will be completed. **18/04/23 - Finance and LIAISON working together on financial resoruce mapping**	COB/MB / External Provider	30/09/2022	30/06/2023	
PP18	**IN PROGRESS**	28.01.22	Develop a new process to produce estimates with prescribed verbiage which ensures that the Trust complies with the Unfair Trading Practices Act.	Audit Committee	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**18/04/23 - Finance and LIAISON working together on financial resoruce mapping**	External provider	31/05/2022	30/06/2023	
PP20	**IN PROGRESS**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	Audit Committee	21/11/2022 - Tarrif will be updated in line with contract discussions as in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Finance and LIAISON working together on financial resource mapping**	External provider	31/07/2022	30/06/2023	
MEDICAL GOVERNANCE									
PP8	**IN PROGRESS**	28.01.22	Establish Clinical Advisory Committee	Quality, Safety & Performance	Private Patient Consultant Engagement Meeting took place on the 14th December 2022 and the establishment of a Clinical Advisory Committee was discussed. Terms of Reference to be shared and Clinical Lead (who will Chair the COmmittee) to be appointed.	Clinical Director	30/04/2022	31/03/2023	
COMMERCIAL									
PP21	**IN PROGRESS**	28.01.22	Develop a private patient tariff for both self-pay and insured private patients	Audit Committee	Refer to narrative in PP17.	External provider	31/07/2022	30/06/2023	
PP22	**IN PROGRESS**	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	Audit Committee	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Revised processes have been established and are being rolled out.**	External provider	31/07/2022	30/06/2023	
PP23	**CLOSED**	28.01.22	Update the Undertaking to Pay form to include all the necessary legal and GDPR rules	Audit Committee	Form up-dated, which included input from the Information Governance Manager. Completed 23.06.21.	AMS	30/09/2022	N/A	Updated Undertaking to Pay form
PP25	**IN PROGRESS**	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	Audit Committee	Refer to narrative in PP17.	External provider	31/07/2022	30/06/2023	

Improvement Plan - Private Patient Service

Date Updated: 18/04/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
PP27	**CLOSED**	28.01.22	Increase private income through exploiting opportunities to expand the clinical scope of the private patient service.	Audit Committee	increased income by ensuring all activity is billed in line with process. Now charging for some element of care previously not charged for. Currently discussing expansion of radiology service. Any significant changes are closely linked to Strategy. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**18/04/23 - Recurrent CIP identified from recovery of costs within existing scope of service offer**	Clinical Lead	31/07/2022	31/03/2023	
PP28	**CLOSED**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	Audit Committee	REPEAT PP20	External provider	31/07/2022	N/A	
OPERATIONAL									
PP30	**CLOSED**	28.01.22	Develop training plan for PP staff	Quality, Safety & Performance	Training plans in place for all staff members. There has been a delay in securing the services of an external specialist provider therefore this has not been progressed.	AMS	31/07/2022	N/A	
PP31	**CLOSED**	28.01.22	Integrate Medical Secretary into Health Records department	Quality, Safety & Performance	The Medical Secretary has been integrated in to the Medical Records Department, specifically in terms of attending monthly meetings and inclusion in regular and adhoc communications/up-dates. The ability to physically co-locate as has been delayed due to space limitations in light of covid restrictions.	TB	28/02/2022	N/A	
PP10	**OPEN**	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	Quality, Safety & Performance	Discussions have commenced SLT leads on the current gaps in service provision within the PP pathway. The approval of the overarching policy will be integral to this action. 21/11/2022 - Refer to narrative in PP1.	EGE/AMS	30/06/2022	31/03/2023	
PP14	**IN PROGRESS**	28.01.22	Review management structure and reporting arrangements	Quality, Safety & Performance	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Revised operating stuctures under review and being recruited to**	COB / External Provider	30/04/2022	31/05/2023	
PP15	**CLOSED**	28.01.22	Review patient management arrangements by creating a Senior PP Manager role reporting to the COO	Quality, Safety & Performance	22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - Role linked to potential expansion, progression of which is paused.**	COB / External Provider	30/04/2022	31/03/2023	

Improvement Plan - Private Patient Service

Date Updated: 18/04/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
PP37	**OPEN**	28.01.22	Procure or develop a private patient management system that will enable production of regular management information including a private patient activity report.	Audit Committee	The CANISC Patient Administration System is the primarily solution for this information. Therefore an additional system is not required. Three standard reports have been established:- Report 1 - General overview of private patient activity for both inpatient and outpatients Report 2 - Private inpatient activity for a current day Report 3 - Radiology attendances, including exam type Patient KPI report (activity and phlebo) established (to be reviewed and signed off) Requirements provided to provide a single report that captures all activity at a patient level (which can be filter, including attendance month, year, department, activity type etc). This is dependent upon BI resources and prioritisation. BI resource currently focussed on implementation of DHCR. Dedicated finance resource required to produce monthly report for Senior Leadership Team. WPAS has now been deployed. There is ongoing work to ensure SOPs etc are aligned to ensure PPs are correctly recorded in the system to support ongoing activity	WJ	30/05/2022	31/03/2023	PPMG agreed that current systems appropriate to capture information.
PP41	**OPEN**	28.01.22	Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk.	Audit Committee	No update provided	DO	30/05/2022	N/A	
PP43	**IN PROGRESS**	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Audit Committee	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. **18/04/23 - HCaH contract reviewed and maximised for Blood Testing, but not the wider Chemo service - all contract negotiations aligned to Q1 delivery.**	PW	31/07/2022	30/06/2023	

Action Plan - Private Patient Service

Date Updated:

Ref No.	Status	Date	Recommendation/Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome	Evidence for Closure
PP3	CLOSED	28.01.22	Integrate business planning into Trust IMTP process	Strategic Development	The service management group feeds into the wider Operational Services and Delivery Directorate where such business planning takes place. This feeds into the IMTP process. Content for 2023/24 IMTP will be based on outcome of strategy discussions and direction.	AMS	31/07/2022	N/A	Agreed private patient strategy will feed into Trust IMTP proess which conlcudes at end of March	
PP5	CLOSED	28.01.22	Develop/procure and implement patient management and information system	Quality, Safety & Performance	Electronic patient record in place. The Digital Health and Care Record will be implemented across the Private Patient Service. Standard reports agreed with the Business Intelligence Team.	AMS	31/07/2022	N/A		
PP8	CLOSED	28.01.22	Produce job planning guidance to define NHS and private patient work within Consultant job plans	Quality, Safety & Performance	National template used which is incorporated into job planning discussions.	EGE/NH	30/04/2022	N/A		
PP9	CLOSED	28.01.22	Implement changes to the existing clinical governance arrangements which provide assurance that private patient work is subject, as a minimum, to the same scrutiny and level of service for NHS patients.	Quality, Safety & Performance	Common systems, policies and procedures used for NHS and private patients to collect clinical information, risks, incidents, complaints and claims. Patients can be idenfied by certain fields.These are monitored at a monthly management group. Information is included in indivdiaul apprasials as part of the standard process.	JA	30/04/2022	N/A		
PP12	CLOSED	28.01.22	Introduce private patient contract/agreement to be signed by all staff undertaking PP practice.	Quality, Safety & Performance	Process in place for Consultants who undertake private practice	EGE/AMS	31/07/2022	N/A		
PP13	CLOSED	28.01.22	Ensure rolling programme in place to ensure workforce agreements are reviewed in a timely manner	Quality, Safety & Performance	Cycle of business in place for the service and under development for management group.	AMS	30/04/2022	N/A		
PP23	CLOSED	28.01.22	Update the Undertaking to Pay form to include all the necessary legal and GDPR rules	Audit Committee	Form up-dated, which included input from the Information Governance Manager. Completed 23.06.21.	AMS	30/09/2022	N/A		Evidence PP23
PP28	CLOSED	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	Audit Committee	REPEAT PP20	External provider	31/07/2022	N/A	Suggest closure as a repeat action.	
PP30	CLOSED	28.01.22	Develop training plan for PP staff	Quality, Safety & Performance	Training plans in place for all staff members. There has been a delay in securing the services of an external specialist provider therefore this has not been progressed.	AMS	31/07/2022	N/A		Evidence PP30
PP31	CLOSED	28.01.22	Integrate Medical Secretary into Health Records department	Quality, Safety & Performance	The Medical Secretary has been integrated in to the Medical Records Department, specifically in terms of attending monthly meetings and inclusion in regular and adhoc communications/up-dates. The ability to physically co-locate as has been delayed due to space limitations in light of covid restrictions.	TB	28/02/2022	N/A		
PP33	CLOSED	28.01.22	Establish a monthly Private Patient Business Meeting to review the results for the period including financial results, patient volumes, operational problems, marketing, etc.	Quality, Safety & Performance	Operational Management Group to meet monthly from June 2022. Dedicated finance support required.	LM	30/09/2022	N/A		
PP38	CLOSED	28.01.22	Establish a formal regular 1:1 meeting with the Private Patient Manager and their line manager		The service transferred into a new management structure and 1:1 and team meetings were established immediately. Complete 30 March 2021	AMS	30/03/2022	N/A		
PP39	CLOSED	28.01.22	Review and improve current preauthorisation management procedure for enfranchised (insured) patients.	Quality, Safety & Performance	Pre-authorisation process in place, currently being managed by the Private Patient Manager.	LB	31/07/2022	N/A		
PP40	CLOSED	28.01.22	Review and where required update arrangements for communicating charges to self-pay patients.	Quality, Safety & Performance	SOP developed/in place for the management of 'top-up' patients. Process in place for self payers. SOP to be submitted to the Private Patient Management Group for approval for governance purposes but revisions already approved by line management,	LB	31/07/2022	N/A		
PP41	OPEN	28.01.22	Consult with clinicians and realign payment arrangements for their fees to ensure the credit risk from non-payment is shared between the Trust and clinicians rather than the current arrangement where the Trust bears all the risk.	Audit Committee	No update provided	DO	30/05/2022	N/A		

Action Plan - Private Patient Service

Date Updated:

Ref No.	Status	Date	Recommendation/Issue to be addressed	Assurance Committee	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome	Evidence for Closure
PP42	CLOSED	28.01.22	Review private patient debt management arrangements and develop agreed principles and new processes to mitigate bad debt risks.	Audit Committee	Review of Private Patient debt completed back to 2016. Unapplied and Unallocated lists reviewed, private patient monies identified and process in place to link this to the correct budget, reducing debt position. Pre-payment in place for 'top-up' patients. Direct links established with Insurance Companies to prevent on-going shortfalls, and follow-up following bill being issued.	AMS	30/05/2022	N/A		
PP28	CLOSED	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at	Audit Committee	REPEAT PP20	External provider	31/07/2022	N/A		
PP35	CLOSED	28.01.22	Train all staff involved in private patient services in the operating procedures.	Quality, Safety & Performance	The Private Patient Team have completed training against operating procedures. This will be reflected within PADRs due for completion end of December 2022.	AMS	30/09/2022			
PP36	CLOSED	28.01.22	Implement new procedures which clearly differentiate overseas and private patients within the patient health record and other systems.	Quality, Safety & Performance	WPAS implemented 14.11.22. Functionality is available within this solution to determine the patient classification at the point of registration/referral. Overseas and Private Patient classifications are separated within the solution to enable easy identification.	AMS	30/05/2022	30/11/2022		
PP24	CLOSED	28.01.22	Develop a Terms of Business statement for sharing with patients before any care is provided.	Audit Committee	Signed agreement of undertaking to pay in place. Reviewed by Head of Service.	PP Manager	31/07/2022	31/03/2022	Suggest closure at meeting on 22.12.22 meeting	
PP29	CLOSED	28.01.22	Review all billing practices and revise where necessary to ensure there is a reduced risk of the insurers 6-month treatment date billing cut off being breached	Audit Committee	Review of billing has been completed by the Private Patient Manager. Electronic billing via Healthcode has recommenced which minimises delays.	PP Manager	30/03/2022	31/07/2022	Suggest closure at meeting on 22.12.22 meeting	
PP42	CLOSED	28.01.22	Review private patient debt management arrangements and develop agreed principles and new processes to mitigate bad debt risks.	Audit Committee	Review of Private Patient debt completed back to 2016. Unapplied and Unallocated lists reviewed, private patient monies identified and process in place to link this to the correct budget, reducing debt	AMS	30/05/2022	N/A		
PP38	CLOSED	28.01.22	Establish a formal regular 1:1 meeting with the Private Patient Manager and their line manager		The service transferred into a new management structure and 1:1 and team meetings were established immediately. Complete 30 March 2021	AMS	30/03/2022	N/A		
PP39	CLOSED	28.01.22	Review and improve current preauthorisation management procedure for enfranchised (insured) patients.	Quality, Safety & Performance	Pre-authorisation process in place, currently being managed by the Private Patient Manager.	LB	31/07/2022	N/A		
PP40	CLOSED	28.01.22	Review and where required update arrangements for communicating charges to self-pay patients.	Quality, Safety & Performance	SOP developed/in place for the management of 'top-up' patients. Process in place for self payers. SOP to be submitted to the Private Patient Management Group for approval for governance purposes but revisions already approved by line management,	LB	31/07/2022	N/A		
PP33	CLOSED	28.01.22	Establish a monthly Private Patient Business Meeting to review the results for the period including financial results, patient volumes, operational problems, marketing, etc.	Quality, Safety & Performance	Operational Management Group to meet monthly from June 2022. Dedicated finance support required.	LM	30/09/2022	N/A		
PP7	CLOSED	28.01.22	Evaluate and review all clinical professionals undertaking private practice, and privilege rights, as well as appropriate indemnity insurance.	Quality, Safety & Performance	Discussions underway with regard to process requriements.	Clinical Director	30/04/2022	30/09/2022		Consultants with PP Practice March 2023.xlsx

AUDIT COMMITTEE

AUDIT REPORT RECOMMENDATIONS ACTIONS

DATE OF MEETING	25/04/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

1.2 This report focuses on:

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

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

1.2.3 actions that are not yet due for completion, those assessed as on track for delivery by the agreed date **(Yellow Status)** and those that are assessed as currently not on track for delivery by the agreed date **(Orange Status);**

1.2.4 those actions that have been completed (Blue Status) for which the Director and Officer leads received Audit Committee agreement to close actions in previous meetings.

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

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

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1. Context

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

2.1.2 At the July '22 Audit Committee it was decided to review all audit report actions twice a year to ensure focus is maintained on actions, which took place at the meeting 4th October 2022 and again today 25th April 2023. On the 12th January 2023 the Audit Committee were requested to review **Red and Green Status** actions only.

2.1.3 Following the January '23 Audit Committee, further updates from Action owners on implementation progress were sought:

- 16th January 2023 requesting a response by the 30th January 2023 – January Update Column.
- 6th February 2023 requesting a response by the 15th February 2023. – February Update Column.

Any further extensions to implementation dates were also requested to be provided in the 'Requested Extension Date' and 'Extension (Months)' columns of the Tracker. These updates were taken to the Executive Management Board.

2.1.4 Further requests for updates were then sought on the 7th March 2023 requesting responses by the 5th April 2023, with reminders being sent for responses on the 22nd March 2023 – in preparation for the April Audit Committee, these responses have been added to the 'March / April 2023 Updates' column in the Tracker. Any further extensions to implementation dates were also requested to be provided in the 'Requested Extension Date' and 'Extension (Months)' columns of the Tracker.

2.1.5 To aid forward planning, a table was shared with Executive / Director Leads which provided the deadlines for responses on all Tracker updates until August 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
March / April	05 April 2023	02 May 2023	25 April 2023
May	17 May 2023	05 June 2023	
June	15 June 2023	29 June 2023	July 2023 (Date TBC)
July	17 July 2023	31 July 2023	
August	16 August 2023	31 August 2023	

2.1.6 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 4 Internal audit reports were added to the Audit Action Tracker following the January '23 Audit Committee and consisted of 12 Matters' arising. In response to these Matters arising management identified 27 recommendations / actions in total, of which 11 were medium priority, 12 low priority and 4 high priority. The 4 reports added were:

- Managing Attendance at Work – Divisional Deep Dive
- Patient & Donor Experience
- New Velindre Cancer Centre Development: Contract Management
- Performance Management Framework

One advisory report was added, which is listed below:

- Decarbonisation

To Note: The New Velindre Cancer Centre Development Contract Management Report also included previous recommendations that closed out 3 recommendations / actions on the nVCC Contract Management 2021 Report. The follow up recommendations / actions added to the New Velindre Cancer Centre Development Contract Management Report section of the Tracker have not been included in the figures within this report.

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

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

				Summary of Recommendations				
Review	**Year**	**Status**	**Rating**	**High**	**Medium**	**Low**	**Total**	**Audit Committee**
Finance & Service Sustainability: Budgetary Control & Savings Plans	22/23	Final Report	Reasonable	0	4	4	8	Oct-22
Staff Wellbeing	22/23	Final Report	Advisory					Oct-22
Research & Development	22/23	Final Report	Substantial	N/A	N/A	N/A	N/A	Oct-22
Divisional Deep Dive (Managing Attendance at Work)	22/23	Final Report	Reasonable	1	3	4	8	Jan-23
Digital Health & Care Record	22/23	Final Report	Substantial	N/A	N/A	N/A	N/A	Jan-23
Ways of Working	N/A	Cancelled	N/A					

Quality & Safety Framework	22/23	Deferred	N/A					
Private & Overseas Patients	23/24	Deferred	N/A					
Clinical Audit	22/23	Draft	Reasonable	1	3	3	7	Out of Committee
Patient & Donor Experience	22/23	Final	Reasonable	0	3	0	3	Jan-23
Capital Provision	22/23	Planning						
Cyber Security	22/23	Planning						
Information Governance	22/23	Planning						
Performance Management Framework	22/23	Draft	Reasonable	0	3	8	11	Jan-23
Follow Up	22/23	Not Started						
Strategic Transformation Assurance	22/23	Not Started						
Capital & Estates								
Estates Assurance - Decarbonisation	22/23	Final	Advisory					Jan-23
				Summary of Recommendations				
Review	**Year**	**Status**	**Rating**	**High**	**Medium**	**Low**	**Total**	**Audit Committee**
New VCC Integrated Audit and Assurance Plan:								
Enabling Works Security Contract	22/23	Final Report	Advisory					Jul-22
Enabling Works (deferred from 21/22)	22/23	Final Report	Reasonable	0	2	4	6	Oct-22
Enabling Works	22/23	Fieldwork						
MIM Contract Management	22/23	Final	Limited	1	0	0	0	Jan-23
MIM Design & Change Management	22/23	Planning						
MIM Approvals	22/23	Not Started						
MIM Planning	22/23	Not Started						
MIM Procurement	22/23	Not Started						
Validation of Management Actions	22/23	Not Started						
Total				**3**	**18**	**23**	**44**	
Final Report				**2**	**12**	**12**	**26**	
Draft Report				**1**	**6**	**11**	**18**	

2.2.3 Work undertaken by Management / Officer leads to complete actions since the January ’23 Audit Committee has resulted in 40 Internal Audit actions being completed which are being recommended to the Audit Committee for closure in its April ’23 meeting.

2.2.4 The table below provides a summary of the movement in total internal audit actions from January ‘23 Audit Committee to April ’23 Audit Committee.

2.2.5 The tables below provide a summary of the audit action status position as of April '23.

Internal Audit Report Actions					
	TOTAL ACTIONS	**HIGH**	**MEDIUM**	**LOW**	**N/A**
January '23 Audit Committee					
Total Outstanding Actions	56	1	32	23	0
Less: Completed Actions (Green) – Agreed to close (Changed to Blue)	(11)		(4)	(7)	
Following January '23 Audit Committee	45	1	28	16	0
Add: Total Actions from new reports taken to January '23 Committee	27	4	11	12	0
Total Outstanding Actions @ 30 January '23	**72**	**5**	**39**	**28**	**0**
Completed Actions (Green) - propose close (Blue)	5	0	4	1	0
Total Outstanding Actions @ 15 February '23	**72**	**5**	**39**	**28**	**0**
Completed Actions (Green) - propose close (Blue)	0	0	0	0	0
Total Outstanding Actions @ 05 April '23	**72**	**5**	**39**	**28**	**0**
Completed Actions (Green) - propose close (Blue)	35	3	21	11	0
Total Outstanding Actions brought to April '23 Audit Committee	**72**	**5**	**39**	**28**	**0**
Total Completed Actions (Green) - propose close (Blue)	40	3	25	12	0

2.2.6 The tables below provide a summary of the audit action status position reported at the January '23 Audit Committee to provide an indication of the changes in Actions from January '23 to April '23.

December '22 – Internal Audit

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

Action Status by Prioritisation Timescale

Priority	Total	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 Dec '22	Action complete Nov '22	Action complete Oct '22	Closed
High	1			1				5
Medium	32	2		26	1	3		52
Low	23			16		3	4	32
N/A (Advisory Audit)	0							10
Total (Blue Status Actions)	**56**	**2**	**0**	**43**	**1**	**6**	**4**	99
% (Blue Status Actions)	**100%**	**4%**	**0%**	**76%**	**2%**	**11%**	**7%**	**N/A**

Action Status by Executive / Director Lead

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

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

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

March / April '23 – Internal Audit

Priority	2015/16	2019/20	2020/21	2021/22	Total
No. of Audit Reports	1	2	5	21	**29**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	0	1	1	70	**72**

Action Status by Prioritisation Timescale

Priority	Total	Implement action 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 January 2023	Action complete February 2023	Action complete March / April 2023	Closed
High	5	1		1			3	5
Medium	39	7		7	4		21	56
Low	28	5		11	1		11	39
N/A (Advisory Audit)	0							10
Total (- Blue Status Actions)	**72**	**13**	**0**	**19**	**5**	**0**	**35**	110
% (- Blue Status Actions)	**100%**	**18%**	**0%**	**26%**	**7%**	**0%**	**49%**	**N/A**

Action Status by Executive / Director Lead

Executive Lead	Total	Implementation 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 January 2023	Action complete February 2023	Action complete March / April 2023	Closed
Executive Director of Finance	8	2		5			1	51
Director of Strategic Transformation, Planning & Digital	9			9				17
Director of Governance & Chief of Staff	19						19	1
Director of Nursing, AHPs & Health Science	7	3		1			3	1
Director of OD and Workforce	4						4	4
Chief Operating Officer	8	2		1	2		3	22
TCS nVCC Project Director	15	6		3	3		3	4
Executive Director of Finance and Chief Operating Officer	0							2
Chief Operating Officer and Director of Governance & Chief of Staff	2						2	8
Total	**72**	**13**	**0**	**19**	**5**	**0**	**35**	110

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

Priority	2021/22	Total
High	1	1
Medium	7	7
Low	5	5
N/A (Advisory Audit)		
Total	**13**	**13**

2.2.7 There are 13 actions (18%) for which the implementation date has passed and management action is not complete (Red).

2.2.8 There are 40 actions (56%) since the January '23 Audit Committee that have been completed. The April '23 Audit Committee will be asked for agreement to close these actions.

2.2.9 There are 19 actions (26%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.3 External Audit Actions Analysis

2.3.1 3 External audit reports were added to the Audit Action Tracker following the January '23 Audit Committee and consisted of 10 Matters' arising. In response to these Matters arising management identified 14 recommendations / actions in total. The 3 reports added were:

- Review of Quality Governance Arrangements - VUNHST
- Reviewing Approach to Equality Impact Assessments
- The National Fraud Initiative in Wales 2020-21

2.3.2 Management / Officer leads have completed 6 further actions since the January '23 Audit Committee which are recommended for closure.

2.3.3 The tables below provide a summary of the audit action status position that was reported at the January '23 Audit Committee to provide an indication of the changes.

December '22 – External Audit

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

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

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

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete November 2022	Action complete October 2022	Closed
High	1				1		2
Medium	2			2			1
Low	0						2
N/A (Advisory Audit)	8			3		5	13
Total	**11**	**0**	**0**	**5**	**1**	**5**	**18**
%	**100%**	**0%**	**0%**	**45.3%**	**9.3%**	**45.4%**	**N/A**

Action Status by Executive / Director Lead

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

March / April ’23 – External Audit

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

Priority	2019/20	2021/22	Total
No. of Audit Reports	1	6	**7**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	1	18	**19**

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 January 2023	Action complete February 2023	Action complete March / April 2023	Closed
High	0							3
Medium	2						2	1
Low	0							2
N/A (Advisory Audit)	17	1			2		14	18
Total	**19**	**1**	**0**	**0**	**2**	**0**	**16**	**24**
%	**100%**	**5%**	**0%**	**0%**	**11%**	**0%**	**84%**	**N/A**

Action Status by Executive / Director Lead

Executive / Director Lead	Total	Implementation 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 January 2023	Action complete February 2023	Action complete March / April 2023	Closed
Executive Director of Finance	4						4	6
Director of Governance & Chief of Staff	9						9	10
Director of Nursing, AHPs & Health	1	1						
Director of OD and Workforce	3				2		1	6
Chief Operating Officer	0							2
Director Corporate Governance and Chief of Staff and Executive Director Nursing, AHP and Health Science.	2						2	
Total	**19**	**1**	**0**	**0**	**2**	**0**	**16**	**24**

2.3.4 There is 1 action (5%) for which the implementation date has passed and management action is not complete (Red).

2.3.5 There are 18 actions (95%) are identified as compete (Green). The Audit Committee will be asked to formally close these complete (Green) actions.

2.4 **Summary of the position as of 25 April 2023:**

- 11 Internal Audit Report actions and 6 External Audit report actions were closed (Blue Status) following the January '23 Audit Committee.
- 40 (56%) Internal Audit Report actions and 18 (95%) External Audit Report actions have been completed **(Green Status)**.
- 19 (26%) Internal Audit report actions are on target for completion by the agreed date **(Yellow Status)**.
- 13 (18%) Internal Audit report action and 1 (5%) External Audit report actions that have passed their agreed implementation date (**Red Status**).

3 IMPACT ASSESSMENT

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

4 RECOMMENDATION

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

4.2 40 Internal Audit report actions (56%) and 18 External Audit report actions (95%) have been completed since the January '23 Audit Committee **(Green Status).** The Committee is asked to **APPROVE** closure of these actions. If agreed these actions will be formally Closed **(Blue Status).**

4.3 13 Internal Audit (18%) and 1 External Audit (5%) report actions have passed the agreed implementation date **(Red Status)** which the Executive / Director lead has asked for agreement to a revised extension date. The Committee is asked to **APPROVE** the extension dates identified.

4.4 The Committee are asked to **NOTE** the actions that are on target for completion by agreed date **(Yellow Status)**.

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 complete previous meeting

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

* Unless a more appropriate timescale is identified /agreed

Velindre UNHS Trust

INTERNAL AUDIT - ESTATES MAINTENANCE					Assurance Rating: Reasonable			Date received at Audit Committee: December 2015		
Column1	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for January 2022 Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
EM2015.1	An estates strategy will be developed; including relevant priorities for the period.	Medium	As highlighted within the audit, the Trust has developed a high level outline estates plan as part of the 3 year Integrated Medium Term Plan. The Trust will aim to develop an estate strategy in accordance with the long term strategy for the future development of the Velindre Cancer Centre and the future estate requirements of the Welsh Blood Service.	Carl James, Director of Strategic Transformation, Planning & Digital	Stephen Lloyd Now undertaken by Jason Hoskins, Assistant Director	~~31st August 2016 AC agreed extension of date to April 2017~~ ~~31st May 2018~~ ~~September 18~~ ~~31st March 2019~~ ~~30 September 2019~~ ~~September 2020~~ ~~December 2020~~ ~~March 2021~~ **Extension requested to 31 May 2021.** **Update 08 Jul 2021: Extension to 30/11/2021.**	Complete	Further engagement is planned for the new year in support of adopting this strategy. Strategy documentation due to be finalised and presented to EMB and Board during Q4 2021/22. Implementation expected Q1 2022/23	Consultation has taken place surrounding the strategies, and comments from earlier EMB have been included in the latest itterations.. The Estates strategy will formally be presented to EMB and Board for sign off in Q1	Complete: Estates Strategy has been signed off by Trust Board May 2022

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

INTERNAL AUDIT -RISK MANAGEMENT					Assurance Rating: Reasonable			Date received at Audit Committee: 28 May 2019				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
RM2019.5	Management needs to ensure that formal Risk Management training is provided for relevant staff that have responsibility for identifying new risks, carrying out risk assessments and updating the DATIX system. Management should review the arrangements in place for the provision of Risk Management advice.	Medium	A Training Needs Assessment (TNA) will be completed to identify training requirements for relevant staff who have responsibility for identifying new risks, carrying out risk assessments and updating the DATIX system. A review of the arrangements in place for the provision of Risk Management advice will be undertaken as part of a wider Executive/Director portfolio review.	Lauren Fear,Director of Corporate Governance & Chief of Staff	~~Lisa Heydon~~ This action now falls with Lauren Fear, Director of Corporate Governance & Chief of Staff	August 2019 Extension to 30 June 2022 requested. November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** Risk training is complete for levels 2 and 3, attendance for this training has been recorded. Level 1 training will be added to ESR learning portfolios on 17.04.2023, completion of online training can be managed via ESR.		

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

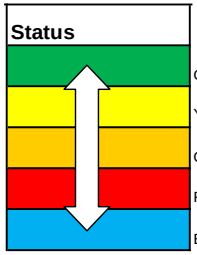
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Final External Audit Report - WAO - Structured Assessment 2019 /20					Assurance Rating: N/A			Date received at Audit Committee: 06 February 2020				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
2019-R3	Board Assurance and Risk Management The Trust should complete the development of its BAF with pace, ensuring that it is appropriately underpinned by up-to-date risk management arrangements. Specifically, the Trust should; a) review the principle risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new BAF; b) update the risk management framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; c) provide risk management training to staff and Board members on the resulting changes to the risk management framework.	Medium	A BAF which triangulates risk, performance and assurance is planned for implementation in 2020-21, and is a priority of the Interim Director of Corporate Governance who commenced with the Trust on the 2nd December 2019.	Lauren Fear, Director of Corporate Governance& Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	Extension to 30 June 2022 requested. Update May 2022: Extension Requested to 19 July 2022. November 2022 out of Committee Extension agreed: c) 31 January 2023 (a and b complete)	Complete			**Complete.** TAF is in place and regularly updated before submission through the committee and Board cycle. A new template has been developed, to include a stronger links to relevant risks under the strategic. The new template will be launched in April 2023, this will include a how to guide and support for Exec leads and their teams to complete and update the TAF going forward.		
	Tracking Internal and External audit recommendations 2018 R4b Implement a mechanism for ensuring that when Internal Audit and External Audit actions are completed, the responsible officer provides a brief summary of the actions taken to the Audit Committee, along with a request to close the action.	High		Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	No progress (overdue) No progress has been made on this recommendation. Update May 2022: Extension Requested to 19 July 2022	Action Closed	n/a	n/a	n/a	n/a	n/a

Audit Action Plan



Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - management action not complete

Blue - Action closed previous meeting

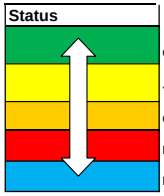
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

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

Audit Action Plan



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Medium	< 1 month *
High	Immediate *

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Velindre UNHS Trust

INTERNAL AUDIT - Governance Arrangements during COVID-19 Pandemic				Assurance Rating : N/A Advisory Audit				Date received at Audit Committee: 08 October 2020		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2022 Audit Committee	Update May 2022 Audit Committee	Update July 2022 Audit Committee
11	**Information Governance** * The need to maintain privacy in the household when using video conference/telephone call or other applicable work from other household members. * Ensuring that laptops are locked when not in use/away from the desk. This is even more important in a public environment if agile working is to be promoted, for example, coffee shops. Consideration could be given to reducing the screen lock functionality within Windows. * How physical copies of information are held and how they should be securely stored away from other household members/visitors. * The risk that staff using their own devices at home are potentially more susceptible to malware/phishing attacks, as they may have insufficient security on their phones/home computers etc. This is likely to be more relevant with people able to access the OneDrive/Office 365 with just an internet connection from any device.	N/A		Matthew Bunce , Executive Director of Finance	Ian Bevan, Head of Information Governance	30/06/2021. **Update: 08 July 2021: Extention to 30/09/2021.** **Update October 2021 meeting: Extension agreed 31 December 2021 Estimated Completion 31 January 2022.** **Extention requested to May 2022.** **Extension requested to July 2022**	Action Closed	The Head of IG came in to post on 29 Nov 21. A review of all IG policies is underway with the aim of bringing them up to date, aligning them with UK GDPR (Post-Brexit) and include remote working considerations. The estimated completion date is 31 Jan 22. The first Policy to be reviewed is the Data Protection Policy, the draft of which now incorporates significant changes in an expanded Section 6 (Training, Awareness and Practical Considerations). The revised Policy includes all of the recommended points from the Internal Audit report (Column B) as well as other additIonal practical remote working considerations which will be cross referred across all IG policies. Training will be delivered in the new year to "bolt on" to the existing ESR package to support Policy and to re-inforce remote working considerations on a risk-based approach basis (i.e. - areas within the Trust which present the highest risk/balanced against compliance data).	The policies are being worked on with the aim of getting them to EMB during May 22.	IG policies and cover paper which gives overview of changes to Policies submitted to EMB Run for approval on 1st July 2022. Policies submitted are: • Data Protection and Confidentiality Policy • Records Management Policy • Confidentiality Breach Reporting Policy • Freedom of Information Act Policy All policies have been through a socialisation process within the Corporate area, WBS and VCC.

Audit Action Plan

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

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Velindre UNHS Trust

Final Internal Audit Report 2020/2021 - Velindre Cancer Centre Divisional Review | **Assurance Rating: Reasonable** | **Date received at Audit Committee: 22 March 2021**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
	Senior Management should ensure that all risks are managed in accordance with the Trust's risk mangement arrangements. Management should ensure that Datix training is provided for all appropriate staff.	High	Datix and risk management training will be provided in conjunction with the role of out of the new Datix risk module, due to go live April 2021.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	July 2021 Extension to 30 June 2022 requested. Update May 2022: Extension Requested to 19 July 2022. November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** Risk training is complete for levels 2 and 3, attendance for this training has been recorded. Level 1 training will be added to ESR learning portfolios on 17.04.2023, completion of online training can be managed via ESR.		

THIS IS AN ADVISORY AUDIT

Audit Action Plan

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

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Velindre UNHS Trust

Final Internal Audit Report 2020-2021 - IM&T Control and Risk Assessment - Advisory Report					Advisory Audit			Date received at Audit Committee: 22 March 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022
4	Departmentally managed systems should comply with good practice for the management of ICT. Digital services should produce good practice guidance documentation for the Trust overall, with all departments required to comply for areas such as: • BYOD; and • Change control.	N/A	Revised governance arrangements (including the establishment of a Digital Programme Board) will set out the approach for how all departments are required to implement and manage ICT. Where relevant, appropriate documentation will be developed by the Digital Services team to ensure staff are aware of their responsibilities and that clear roles and responsibilities between the Digital Services team and other departments are clearly set out.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	Awaiting confirmation of revised Trust governance procedures. Extension Requested to 19 July 2022	Completed: appropriate documented procedures in place for management of ICT within Digital Service, managed in line with ITIL Service Management arrangements. Recommendation not related to overall goverance arrangments / new ways of working change programme not connected to this recommendation	n/a
5	Work on the digital strategy should be completed. This work should include an evaluation of the current position of the Trust in relation to both the external environment and current ways of working in order to provide a baseline position from which to work.	N/A	A refreshed Digital Strategy to be approved by the Trust Board following a process of engagement and consultation with stakeholders.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 3 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	Digital Strategy scheduled to be presented for Trust Board approval in May 2022. Extension Requested to 19 July 2022	Action completed - Digital Strategy approved at May 2022 Trust Board.	n/a
6	The development of the digital strategy should consider the wider digital strategy implications and the supporting digital infrastructure. Consideration should also be given to establishing a strategy governance and management group such as a Digital Programme Board to oversee, coordinate and prioritise digital strategy issues.	N/A	A new pan Trust Digital Board will be established for the Trust to oversee and coordinate the digital strategy.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 3 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	Development of proposal to establish Digital Strategy Group to deliver digital strategy developed: to be discussed with Executive Management Board in May 2022 Internal discussions commenced with a view to establish an interim group who can perform this role. Extension Requested to 19 July 2022	Complete: Digital Strategy approved in May 2022. Wider Trust governance arrangements under ongoing discussion. Consideration of need to establish Trust-wide Digital Board discussed with CEO as part of new organisational design (will be taken forward within Q5 / organisational design work)	n/a
7	The current position of the Trust should be assessed in relation to the target digital position and the required changes across the business, information, data, applications and technology domains identified, together with the benefits of each change and the implication of a lack of change.	N/A	An assessment of the target Digital position to commence with the approval of the Trust Annual Plan 2021/2022, and then subsequently reviewed with the launch of the new Digital Strategy and reflected in the Digital work plan and completion of the Integrated Medium Term Plan / Annual Plan for 2022/2023.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	Digital Strategy scheduled to be presented for Trust Board approval in May 2022. Extension Requested to 19 July 2022	Completed - Digital Strategy approved at May 2022 Trust Board.	n/a
13	SOPs should be developed that make clear the processes for AV software management and for web and email filtering.	N/A	Standard Operating Procedures are being reviewed and consolidated as part of the new Digital Services function. Appropriate AV SOPs will be aligned and developed to cover all Trust operations.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 2 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	Work to standardise AV approach complete. Standard Operating Procedure drafted - aim to complete in Q1 22/23, for review / approval via QSPP Committee. Extension Requested to 19 July 2022	SOP drafted, awaiting final internal review / sign-off. Aim to complete before mid-July 2022 deadline. Request for extension until September 2022 to allow draft SOPs to go through required goverance process	**COMPLETED** Knowledge bases finalised, covering both AV and email/web filtering.
15	Work to develop the asset management and recording process within VCC should continue. This should include a process for identifying critical assets and regular assessment of the need for replacement of these. The Disposal procedure should be reviewed and updated.	N/A	Baseline asset management audit to be completed Common asset management approach to be adopted VCC and WBS disposal procedures to be consolidated	Carl James, Director of Strategic Transformation, Planning & Digital	Deputy Chief Digital Officer	Quarter 1 2021/2022 Quarter 3 2021/2022 Quarter 1 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	1) Completed. 2) In progress - see October 2021 update. Work to extend into 2022/23. 3) In progress - see October 2021 update. Work to extend into 2022/23.	1) Baseline asset mgmt audit: Completed. 2) Well-established asset management approach within WBS - signficant amount of work involved, being managed alongside current operational workplan. Due for completion end of Q2 202/23. On track for completion end of Q2 22/23 (sept 2022) 3) VCC & WBS disposal procedures consolidated : Completed.	**COMPLETED** (1) and (3) completed as per July 2022 update. (2) Completed - all new assets now recorded on ServicePoint (CMDB). Functional limitations mean alternative software solutions to ServicePoint being explored nationally (part of All Wales Infrastructure Programme), which may result in change of approach in next 12-18months.

THIS IS AN ADVISORY AUDIT

Audit Action Plan

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

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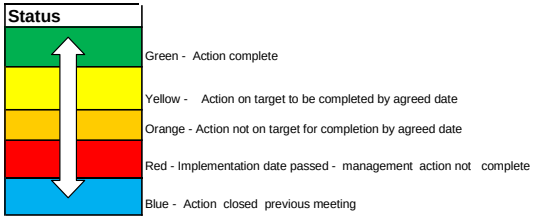
Velindre UNHS Trust

Final Internal Audit Report 2020-2021 - IM&T Control and Risk Assessment - Advisory Report					Advisory Audit			Date received at Audit Committee: 22 March 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2022 Audit Committee	Update July 2022 Audit Committee	Update August 2022
16	A SOP should be developed, with note that critical assets should be fully maintained with up to date patches and firmware, together with a regular assessment of the risk of failure fully.	N/A	Trust-wide patch management SOP to be developed.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 2 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	Patch management tool (PDQ) standardised across the Trust. Standard Operating Procedure drafted - aim to complete in Q1 22/23, for review / approval via QSPP Committee. Extension Requested to 19 July 2022	Revelent SOPs in process of being updated - aim to complete internal review/sign-off by mid-July deadline.	**COMPLETED** PDQ in place to ensure consistent deployment of patches across VUNHST. Key policies updated and approved via QSP Committee in July 2022. Knowledge bases within the team to confirm technical procedure(s) to be followed by team members etc.
17	business critical activities, based on a BIA, and which identifies key stakeholders. This should describe potential disruptive scenarios, the mitigations in place and the residual impact over time. The level of continuity provided should be described in terms of RTO / RPO and discussed with user departments. Options should be provided for departments to move to a greater continuity position if required and the level of provision should then be agreed with departments an executives.	N/A	In progress Business Impact Assessment for Infrastructure complete Digital Services business continuity plans to be developed and fully tested	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2020/2021 Quarter 4 2021/2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	Digital Service BIA completed, due to be refreshed in 2022/23. Cyber Security and IT Business Continuity Incident Response Plans re-drafted, to align with national response plans. To be reviewed (for approval) in May 2022 QSPP Committee. Extension Requested to 19 July 2022	Action completed - incident response plans approved via QSP Committee in May 2022.	n/a
18	A formal Project Management SOP should be developed which sets out the requirements for managing projects, including how and when agile methodologies may be used.	N/A	Standard Operating Procedures for Project and Programme Management will need to be aligned with wider Trust Programme Offices. Work has commenced on the standardisation of roles and templates. SOP will be developed as part of this work programme.	Carl James, Director of Strategic Transformation, Planning & Digital	David Mason-Hawes, Head of Digital Delivery Business Systems	Quarter 4 2021/2022	Action Closed	As per October 2021 update.	Completed: Digital SOP developed as interim, whilst Trust wide approach considered. Process being established for accepting new projects outside of annual plan. New Service Request Form drafted and new internal digital governance structure agreed for the management and prioritisation of these requests, whilst ensuring to link with WBC SMT and VCC Velindre Futures.	n/a

Audit Action Plan



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

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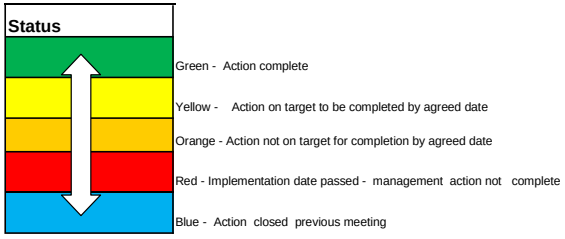
Velindre UNHS Trust

Final Internal Audit Report 2020/2021 New Velindre Cancer					Assurance Rating: Substantial				Date received at Audit Committee: 08 July 2021	
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update September 2022	Update November 2022	Requested Extension Date
2	Succession planning for vacant posts should be considered in readiness for the next stage of the project (O).	Low	Agreed. The Project reviews organisational structures for each phase of the EW and nVCC Project(s). If any post becomes vacant, the Project(s) will review the requirements of the Project(s) and a decisionon recruitment is made. In addition, the Project Director will consider internal staff development opportunities as part of the review.	David Powell, Project Director	David Powell, Project Director	Ongoing	Action Closed		Update October 2022: Closed this recommendation within the 2021/22 MIM Governance report (issued February 2022) so can be closed on the tracker. The following narrative was reported: From Internal Audit attendance at the Project Board meetings, it is recognised that there has been a recruitment campaign to appoint into vacant posts, with some appointments having been made. However, it is also noted that some posts (i.e. Digital) have been difficult to appoint to; but that steps are being taken for discussions with recruitment agencies, as well as the standard NHS jobs application route, to continue to look for appropriate candidates. Conclusion: Closed, recognising that whilst the requirements of the recommendation have been addressed by the Trust, the successful appointment of individuals into the vacant posts remains an ongoing process.	Update October 2022: Closed this recommendation within the 2021/22 MIM Governance report (issued February 2022) so can be closed on the tracker. The following narrative was reported: From Internal Audit attendance at the Project Board meetings, it is recognised that there has been a recruitment campaign to appoint into vacant posts, with some appointments having been made. However, it is also noted that some posts (i.e. Digital) have been difficult to appoint to; but that steps are being taken for discussions with recruitment agencies, as well as the standard NHS jobs application route, to continue to look for appropriate candidates. Conclusion: Closed, recognising that whilst the requirements of the recommendation have been addressed by the Trust, the successful appointment of individuals into the vacant posts remains an ongoing process.	

Audit Action Plan



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

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

Velindre UNHS Trust

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

Audit Action Plan

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Priority	
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High	Immediate *

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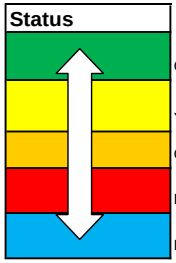
Velindre UNHS Trust

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

Audit Action Plan



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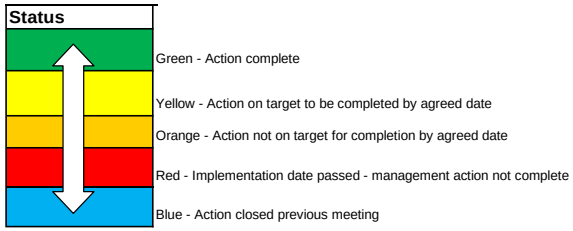
Velindre UNHS Trust

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

Audit Action Plan

Waste



Priority	
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Medium	< 1 month *
High	Immediate *

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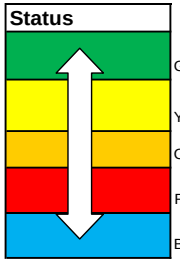
Velindre UNHS Trust

Waste Management - Reasonable Assurance 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2022 Audit Committee	Update August 2022	Update September 2022
	Policy & Procedures (Design). 1.1.a The new Trust-wide waste policy should ensure all key elements of WHTM 07-01 guidance are incorporated.	Medium	1.1.a Accepted - the WHTM will be incorporated in the revised Waste Management Policy.	Carl James, Director of Strategic Transformation, Planning & Digital	Rhiannon Freshney, Environmental Development Officer	December 2021	Action Closed	n/a - Complete May 2021	n/a	n/a
	1.1.b Associated Division policy / procedural documents should be updated to ensure alignment with the overarching policy or removed from publication if no longer applicable.	Medium	1.1.b Accepted. Corporate policy documents will be updated in accordance with the Waste Management Policy. VCC and WBS procedural documents will be updated in accordance with the revised Waste Management Policy and procedures.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC) and Matthew Bellamy, Health & Safety Environmental Officer (WBS)	December 2021 Update May 2022: Extension Requested to 19 July 2022	Action Closed	COMPLETE - VCC procedure aligned with Trust Policy COMPLETE - WBS. SOP reviewed and site practice aligned with Trust Policy .	n/a	n/a
	Governance Structure (Operation). 2.1.a The new sustainability governance structure, including a suitable forum for central oversight of waste management, should be agreed and implemented as soon as possible.	Medium	2.1.a Accepted. The proposal for the Sustainability Management Board will taken to the Executive Management Board for consideration.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins Assistant Director of Estates, Environment & Capital Development	January 2022 Update May 2022: Extension Requested to 19 July 2022	Action Closed	Completed: Waste information is reported to The Cynefin Group in WBS and Operational Management Group in VCC. Central oversight is provided at the ISO14001 Management Group (along with any concerns/initiatives related to waste etc.). It is centrally reviewed against the Annual Net Zero Reporting tool to Welsh Government. Further opportunities may exist to enhance arrangements if the a Trust Sustainability Board is introduced as part of the refreshed organisational working arrangements.	n/a	n/a

Audit Action Plan



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Priority	
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Medium	< 1 month *
High	Immediate *

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Velindre UNHS Trust

Waste Management - Reasonable Assurance 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
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	2.1.b Velindre Cancer Centre should further consider the implementation of an operational Estates forum at which waste management matters can be reported and scrutinised / discussed.	Medium	2.1.b Accepted. VCC will review the options regarding operational estates management.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC	January 2022	Action Closed	n/a - Complete May 2021	n/a	n/a
	Training (Operation). 3.1.a The targeted action plan for environmental awareness training should be taken forward, as soon as possible noting ongoing Covid restrictions.		3.1a Accepted. An action plan for environmental awareness training will be developed.	Carl James, Director of Strategic Transformation, Planning & Digital	Rhiannon Freshney, Environmental Development Officer	March 2022	Action Closed	n/a - Complete May 2021	n/a	n/a
	3.1.b Training needs assessments, and resulting training programmes, should be developed for Division staff handling clinical waste.	Medium	3.1b Accepted. A training needs analysis will be undertaken regarding clinical waste handling at Divisional level. Trainingprogrammeswillbe developed for clinical waste handling at Divisionallevel.	Carl James, Director of Strategic Transformation, Planning & Digital	David Harding, Operational Services Compliance Manager (VCC) and Matthew Bellamy, Health & Safety Environmental Officer (WBS)	March 2022 Update May 2022: Extension Requested to 19 July 2022 **Extention requested to 17 October 2022**	Action Closed	Complete: TNA completed VCC – Provision of training: the TNA identified the porters and domestic staff required clinical waste handling training. This is being delivered with compliance currently at 90% and on-track for 100% by the end of July 2022. Further clinical waste training is being piloted by Operational Services in August and following feedback will be rolled out across the division from September. 2022 WBS – Provision of training: the TNA identified porters required additional clinical waste training. This is being delivered and expected to achieve 100% compliance by end of July 2022. Laboratory staff are also receiving CPD, managed through Q Pulse, with 100% compliance expected by September 2022. Extension requested to October 17th review compliance against September 2022 100% training compliance.		98% of operational service staff dealing with clinical waste are now trained, the remaining are on long term sick or A/L. Training of all staff directly involved in waste segregation completed including Porters. Laboratory staff trained to relevant SOP / POL which includes a clinical waste section. Compliance up to date

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Velindre UNHS Trust

Divisional Review - Risk Management - Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
	New Risk Management Framework (Design). 1.1 a. The Trust should • publish the new Risk Management Framework and supporting documents on its intranet as soonas possible; and • ensure the divisions are aware of the new Framework and its application in practice (see alsomatter arising 2). D	Low	1.1a Recommendation agreed	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear Director of Corporate Governance, Directorof Corporate Governance& Chief of Staff	October 2021 Update May 2022: Extension to 30 June 2022 requested. November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** Risk Policy and Procedure are developed, signed off and can be accessed on the Trust intranet site via the following link: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Corporate-Governance---Risk-Management.aspx		
	1.1 b. Divisional management should: • ensure local risk management procedures are updated to reflect the new Framework;and • ensure all relevant staff are aware of the updatedprocedures.	Low	1.1 b. Divisional response: • WBS: This is an established and documented process at WBS. The audit trail will be kept in Q-Pulse. •	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Extension to 30 June 2022 requested.	Action Closed	n/a	n/a	n/a	n/a	n/a
		Low	− The Quality & Safety Team is in the process of developing a divisional Standard Operating Procedure to align with the Trust Risk Management Framework. Once completed, this will be shared with Directorate leads for review and comment before review and sign off by the VCC Senior Leadership Team. The updated SOP will then be widely circulated to all relevantstaff.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Tracey Langford VCC Quality & Safety Officer	October 2021 Update May 2022: Extension to 30 June 2022 requested. Extension requested to August 2022. Extension requested to November 2022. November 2022 out of Committee Extension agreed: 30 November 2022.	Action Closed	n/a	n/a	n/a	n/a	n/a

Audit Action Plan

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Divisional Review - Risk Management - Final Internal Audit Report 2021/22				Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021				
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	Risk Management Training (Design). 2.1 a. The Trust should ensure: • the new risk management training programme development iscompleted and rolled out assoon as possible; and • mechanisms are in place to capture attendance at risk management training. D	Medium	2.1 a. Recommendation agreed	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	October 2021 Update May 2022: Extension to 30 June 2022 requested. November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** Risk training is complete for levels 2 and 3, attendance for this training has been recorded. Level 1 training will be added to ESR learning portfolios on 17.04.2023, completion of online training can be managed via ESR.		
	2.1 b. Divisional management should ensure that attendance at risk management training is monitored at appropriate forums.	Medium	2.1 b. Divisional response: • WBS: WBS Divisional Managementwill support the roll out of training once finalised and will capture all records of attendance for audit purposes.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Update May 2022: Extension to 30 June 2022 requested.	Action Closed	n/a	n/a	n/a	n/a	n/a
		Medium	2.1 b.• VCC: − The training on the new risk management programme, including training materials, is currently in development and due to be finalised by 5th October 2021. − Training will be made available to all directorates and training compliance will be captured and monitored by Directorate leads and regularly reviewed by at the VCC Quality & Safety Management Group as an assurance measure. − The Senior Leadership Team will monitor training compliance by exception.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Sarah Owen VCC Quality & Safety Manager	October 2021 Update May 2022: Extension to 30 June 2022 requested. Extension requested to August 2022. Extension requested to November 2022. November 2022 out of Committee Extension agreed: 30 November 2022.	Complete			**Complete.** Risk Procedure has been developed to support staff in risk management. Additionally How To guides are in development, some already produced, to support staff in the risk management process and Datix. These will be be available on the Trust Intranet		
	Consistency of approach to risk mangement (Design). 3.1 a. The Trust should implement a mechanism to ensure risk management practice is consistent between the divisions and good practice can be shared. 3.1 b. The Trust should ensure that WBS follows the risk scoring system set out in the Risk Management Framework when reporting to the Board and its Committees.	Low	3.1 Trust response: a & b Recommendation agreed.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance& Chief of Staff	October 2021 Update May 2022: Extension to 30 June 2022 requested. November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** Risk management policy and procedure are both in place and available on the Trust intranet. These have been developed across the Trust with representatives from VCS, WBS and Corporate and all areas are following the same policy and procedure.		

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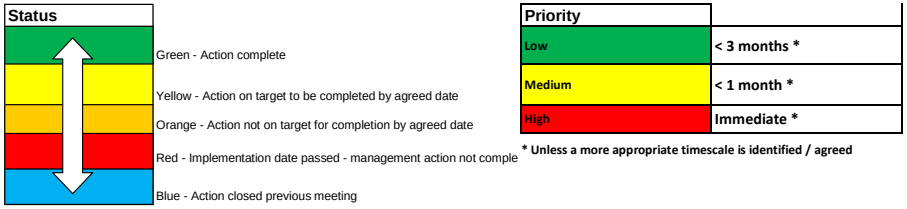
		Low	WBS: a. The WBS Risk Management Team is engaged with the Corporate Governance team to agree an approach to risk management practice that meets the specific regulatory needs of WBS and can be applied consistently across the Trust.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance& Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	October 2021 Update May 2022: Extension to 30 June 2022 requested.	Action Closed	n/a	n/a	n/a	n/a	n/a
		Low	VCC: a. Further discussions needed with Trust Risk Management leads and in turn, Senior Leadership teams of VCC and WBS to agree consistent approach to risk management and sharing of good practice	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance	Lauren Fear, Directorof Corporate Governance& Chief of Staff / Paul Wilkins, Interim Director of VCC / Alan Prosser, Director of WBS	October 2021 Update May 2022: Extension to 30 June 2022 requested. **Requesting extension to September 2022.** **Requesting extension to November2022.**	Action Closed	n/a	n/a	n/a	Closed October 2022: Meeting was held on the 13 October 2022 with representatives from the Divisions and all Corporate Services that identified a range of ways of working to enable consistency and sharing of best practice.	n/a
	Scrutiny of Directorate Risk Registers (Operation). 4.1 a. The Divisional Management Teams should ensure directorate risk registers are monitored and scrutinised frequently at directorate meetings and that meeting minutes evidence this process. 4.1 b. Whilst we appreciate the challenges of the Covid-19 pandemic, the Trust should ensure that it always appropriately evidences governance processes at all levels of the organisation. This requirement should be communicated to the divisions and directorates.	Medium	4.1a WBS response: a. WBS will introduce a review of open risks consistently across all departmental OSG meetings. b. N/A – VCC action only.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Peter Richardson, Head of Quality & Regulation WBS	December 2021 Update May 2022: Extension to 30 June 2022 requested. November 2022 out of Committee Extension agreed: 30 November 2022.	Action Closed	n/a	n/a	n/a	n/a	n/a
		Medium	4.1 a & b. Risk registers will be added as a standing agenda item on all directorate meetings. Minutes will capture discussions had regarding risk.	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	All Directorate leads	Oct-21	**Action Closed**	n/a	n/a	n/a	n/a	n/a
		Medium	4.1 a & b. Governance processes for risk management to be standardised across the divisions and directorates providing assurance to the Quality & Safety Management Group. Modify and set up within Datix to enable dashboards to be produced by directorates	Cath O'Brien, Chief Operating Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff	Sarah Owen, VCC Quality & Safety Manager Sarah Owen, VCC Quality & Safety Manager	October 2021 **Recommended March 2022** **February 2022**	Action Closed	n/a	n/a	n/a	n/a	n/a

Audit Action Plan



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Divisional Review - Incident Management Final Internal Audit Report 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 14 October 2021		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update July 2022 Audit Committee	Update August 2022	Update September 2022
	Incident Reporting and Investigation Policy (Design). 1.1 a. As soon as the Datix O4W system is finalised, the Trust should: • review and update its Incident Reporting and Investigation Policy, incorporating updated definitions on incidents and the good practice identified in the WBS SABRE reporting flowchart; • ensure the updated Policy is approved by the Board; and • ensure the divisions are made aware of the new Policy.	Low	1.1 a. Trust Incident Policy to be reviewed and approved by the Board. Revised Policy to be tabled at EMB on 1st November 2021. The policy is to reflect the new Once for Wales system requirements and the WBS SABRE reporting flowchart. Both Divisional teams to support the policy development to ensure it meets divisional requirements, including definitions aligned to legislation and regulatory requirements specific to WBS.	Cath O'Brien, Chief Operating Officer	Jennie Palmer Trust Quality & Safety Manager Quality leads at VCC & WBS - Sarah Owen (VCC) and Peter Richardson (WBS)	November 2021 **28 February 2022**	Action Closed	n/a - Complete May 2022	n/a	n/a
	1.1 b. Divisional management should • ensure local incident management SOPs are updated to reflect the updated Policy; and • ensure all relevant staff are aware of the updated SOPs	Low	1.1 b. Divisional response: WBS: − Related incident SOPs to be reviewed in line with new policy requirements. Revised SOPs to be issued. − Awareness/training to be provided to WBS staff in relation to new SOPs and recorded as training events in Q-Pulse in line with established processes.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS Peter Richardson, Head of Quality & Regulation WBS	April 2022 May 2022 **Extension requested to 24th July 2022.**	Action Closed	Further review of incident management of SOP's required following MHRA Audit. This will be completed by the 10th July 2022. Training will be completed by the 24th July 2022. **Extension requested to 24th July 2022.**	The SOP has now been revised and updated. The draft SOP is undergoing final operational suitability checks before it is formally issued in Q-pulse on September 5th. The Management Procedure has been reviewed and did not require any further updates.	Complete. The SOP has now been issued and is in place.
		Low	1.1 b VCC: Divisional Quality and Safety Manager will write the incident management SOP to reflect any changes to the Trust Incident Reporting and Investigation Policy.	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager	November 2021	Action Closed	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a
		Medium	VCC: 2.1 a. The Divisional incident management SOP will reflect the requirement of staff to record incidents within the expected timeframe. Incident management SOP will be reviewed by SLT out of committee to ensure timeliness of action.	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCC Quality and Safety Office to facilitate	November 2021	Action Closed	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a
	2.1 c. We understand the Datix O4W system will have the functionality to report on timeliness of recording in Datix. This should be incorporated into divisional reporting on incidents – see matter arising 4 also.	Medium	WBS: 2.1 c. Timeliness of incident reporting will be introduced into Operational Service Group, Regulatory Assurance and Governance Group, and Senior Management Team meetings. once reporting dashboards are available from Datix O4W (Expected Q3 2021/22)	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	January 2022	Action Closed	**Complete.** Timeliness of recording DATIX has been implemented and has been incorporated into SMT reports since January 2022.	n/a	n/a
		Medium	VCC: 2.1 c. The Divisional incident management SOP will reflect the required reporting and escalation	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality & Safty Manager (VCC), supported by the Tracey Langford, Quality & Safety Officer (VCC)	November 2021	Action Closed	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a

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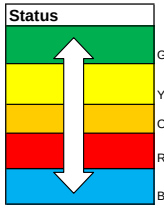

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		Medium	VCC: 3.1a. The Divisional incident management SOP will reflect the need for all staff to record incident investigations in DATIX and the closure process.	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager	November 2021	Action Closed	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a
	3.1 b. Divisional management should maintain a robust audit trail for incident management training delivered.Quality assurance of investigations	Medium	VCC: 3.1b. All incident training records will be maintained and held by the VCC Quality and Safety Officer and departmental managers. VCC to review WBS use of Q-Pulse to assess if transferrable to VCC.	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCC Quality and Safety Officer Amanda Jenkins, Workforce Business Partner / Lisa Miller, Head of Operational Services and Delivery	September 2021 October 2021		n/a Complete January 2022.	n/a	n/a
	3.1 c. Divisional management should:ensure that the quality of incident investigations and compliance with the Policy are incorporated into their audit plans on a cyclical basis; and • consider whether a joint audit of investigations should be undertaken to support further identification of inconsistencies, good practice and/or training needs for incident management across the Trust.	Medium	3.1 c. WBS Quality team to engage with their VCC counterparts to agree a plan for reciprocal joint audits focussing on the quality of incident investigations	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	March 2022	Action Closed	**Complete.** Across Divisional Audits will take place in Quarter 3.	n/a	n/a
		Medium	3.1. c. VCC: Formalise work to include Divisional incident activity to be visible on the Clinical Audit Plan.	Cath O'Brien, Chief Operating Officer	Sara Walters, VCC Clinical Audit Manager / Sarah Owen, VCC Quality and Safety Manager	December 2021	Action Closed	n/a - Complete May 2022	n/a	n/a
	Incident Reporting and Scrutiny (Design). 4.1 a. Divisional management should ensure that incident reporting and scrutiny is undertaken regularly at divisional and directorate / OSG level. The approach should be consistent across the Trust, where appropriate.	Medium	4.1 a WBS response: a. WBS Quality Assurance team to produce a standard KPI template based on the Laboratories OSG for Incident reporting to be used by all Operational Service Group, Regulatory Assurance and Governance Group, and Senior Management Team reports. (also 4.1 c)	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	31 December 2021	Action Closed	The template was introduced. **Proposal to close.** To note further enhancements are being made to the document following MHRA feedback**.**	n/a	n/a
		Medium	4.1 a VCC response:a. Incident Reporting and Investigating Policy will outline the required approach to incident reporting and scrutiny. This will be reflected in the Divisional Incident Management SOP	Cath O'Brien, Chief Operating Officer	Jennie Palmer, Trust Quality and Safety Manager and Sarah Owen, VCC Quality and Safety Manager	30 June 2022	Action Closed	**Complete.** SOP approved at SLT 30 June 2022.	n/a	n/a
	4.1 b. Incident reporting at all levels should include:• defined KPIs (including targets) for incident management, for example, timeliness of recording and investigation closure, level of open incidents, recording of investigations and learning in Datix, etc;• trend monitoring on the above KPIs and other metrics, for example, incidents by type, severity and location; • KPIs and narrative around learning (see matter arising 5); and• the requirement to clearly identify of areas of concern.	Medium	WBS: 4.1 b. This template will take account of the KPI's identified in this audit and will incorporate them in the template once the reporting functionality is in place for Datix O4W.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	31 December 2021	Action Closed	**Complete.** This work has been completed to support the Trust PMF and includes a BI visalisation tool.	n/a	n/a

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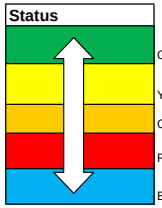

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		Medium	VCC: 4.1 b. Divisional Incident Management SOP will document the set KPI's for the Division and supporting learning narrative. These will be monitored at Directorate meetings by DATIX leads. Any areas of concern escalated to Quality and Safety Management Group	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager and Tracey Lanford, VCC Datix leads	30 June 2022	Action Closed	**Complete.** Trust Incident Policy received in VCC on Friday 8th April 2022. SOP approved at SLT 30 June 2022.	n/a	n/a
	4.1 c. Divisional and directorate / OSG meeting minutes should clearly evidence the scrutiny of incident reports.	Medium	VCC: 4.1 c. DATIX leads will provide information to directorate meetings to facilitate scrutiny and escalation	Cath O'Brien, Chief Operating Officer	Tracey Langford, VCC Datix leads	31-Oct-21	Action Closed	n/a Complete January 2022.	n/a	n/a
		Medium	5.1 a VCC response:a. The Divisional incident management SOP will reflect the need for all staff to record incident investigations in DATIX and the closure process	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager	20 June 2022	Action Closed	**Complete.** Trust Incident Policy received in VCC on Friday 8th April 2022. SOP approved at SLT 30 June 2022.	n/a	n/a
	5.1 b. ensure that incident reporting at all levels (see matter arising 4 also) includes:• KPIs around recording lessons learned in Datix; and• the requirement to clearly identify concerns in trends and lessons for wider sharing (the new report template for Infection Prevention and Control performance could be used to develop this requirement).	Medium	WBS: 5.1 b. The WBS Donor and Patient Clinical Governance groups will amend their monthly incident report templates to include details incidents where lessons learned have not been recorded, and to allow for review and challengewhere appropriate. This is dependent on the reportingfunctionality being in place for Datix O4W.	Cath O'Brien, Chief Operating Officer	Peter Richardson, Head of Quality & Regulation WBS	January 2022	Action Closed	**Complete.** This work has been completed to support the Trust PMF and includes a BI visalisation tool.	n/a	n/a
		Medium	VCC: 5.1 b. Divisional Incident Management SOP will document the set KPI's for the Division and supporting learning narrative. These will be monitored at Directorate meetings by DATIX leads. Any areas of concern escalated to Quality and Safety Management Group	Cath O'Brien, Chief Operating Officer	Sarah Owen, VCC Quality and Safety Manager and Tracey Langford, VCC Datix leads	30 June 2022	Action Closed	**Complete.** All Dashboard in place and being reviewed.	n/a	n/a
	5.1.c. ensure consistency of approach across the Trust to lessons learned, including the use of the AAR database. Should this approach be used, it should be logged in Datix rather than maintained as a separate database.	Medium	VCC 5.1 c. Incident Reporting and Investigating Policy will reflect the learning requirements from an incident investigation This will be included in department meetings and will inform VCC Quality and Safety Management Group. We will continue to work with O4W module once available. implement the learning	Cath O'Brien, Chief Operating Officer	Trust Quality and Safety Manager Sarah Owen, VCC Quality and Safety Manager	March 2022 April 2022	Action Closed	n/a Complete January 2022	n/a	n/a

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External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements					Assurance Rating: N/A			Date Received at Audit Committee: 11 January 2022				
Ref	**Recommendation**	**Priority**	**Management Response**	**Executive/Director Lead**	**Responsible Manager/Officer Lead Department where lead works**	**Agreed Implementation Date**	**Status**	**Update January 2023**	**Update February 2023**	**Update March / April 2023**	**Requested Extension Date**	**Extension (Months)**
Exhibit 1: 2021 Recommendations	**Transparency of Board business** R1 Some committee meeting papers are missing from the website, as are links to recordings of Board meetings. The Trust should ensure that it strengthens the process for the collation, sign off and timely publication of: • Committee meeting papers; and • Recordings of Board meetings.		The Corporate Governance team have introduced a new end to end Board Committee tracker, to strengthen and tighten the process for effective management of Trust Board and Committee meetings and papers.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 1: 2021 Recommendations			A review of the website content has been completed and all missing content has been added	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 1: 2021 Recommendations			All of the Corporate Governance team are to be trained to upload papers directly on the Trust website to further increase resilience.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	March 2022 November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** All staff within the corporate governance team have completed the training and are now able to upload papers directly to the trust website once approved for publication.		
Exhibit 1: 2021 Recommendations			An error led to the deletion of the June 2021 Board meeting recording. A governance note to explain the missing recording was added to the minutes of the July 2021 Board meeting. On the website, the links to the Board meeting recordings were updated to make clear the June 2021 recording is unavailable.	Lauren Fear, Director of Corporate Governance and Chief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2021 (Completed)	Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 1: 2021 Recommendations	**Articulation of strategic priorities** R2 Not all the Trust's strategic priorities in the Annual Plan are supported by specific, timebound actions for delivery, and the intended outcome. In future, the Trust should ensure that all strategic priorities are supported by discrete objectives, each underpinned with specific, timebound actions for delivery and the intended outcome.		We recognise that there are differences in the granularity of the information provided by the service divisions, which in some cases is due to the different type of strategic priority, however, we acknowledge that there are improvements to be made including the identification of timelines and this will be included in the Integrated Medium Term Plan 2022-25.	Cath O'Brien, Chief Operating Officer	Cath O'Brien, Chief Operating Officer and Carl James, Director of Strategic Transformation Planning and Digital	March 2022	Action Closed	n/a	n/a	n/a	n/a	n/a

Audit Action Plan

Velindre UNHS Trust

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Medium	< 1 month *
High	Immediate *

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External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements					Assurance Rating: N/A			Date Received at Audit Committee: 11 January 2022				
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Exhibit 2: progress made on previous year recommendations	**Transparency of Board business 2018** R1 The Trust publishes agendas for public committee meetings in advance of meetings, but not the full set of papers. The Trust should publish all committee papers in advance of public meetings.		Superseded We have made a new recommendation that the Trust should ensure that it strengthens the process for the collation, sign off and publication of committee meeting papers in advance of meetings, and unconfirmed minutes added shortly after meetings. See 2021 Recommendation 1.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director ofCorporate Governance and Chief of Staff	N/A	Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 3: progress made on previous year recommendations	Closing capacity and capability gaps 2018 R8 The Trust should prioritise a review of support services in the two divisions to identify areas that could be integrated to reduce the duplication of effort, increase organisational learning and to inform plans to address capacity and capability gaps.		Complete The Trust has aligned some business support functions where similar services are provided by separate teams within the two divisions. The Trust told us that aligning support functions has enabled it to work more efficiently and ensure organisational learning across the divisions.	Cath O'Brien, Chief Operating Officer	Cath O'Brien, Chief Operating Officer		Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 4: progress made on previous year recommendations	**Monitoring delivery of strategic priorities 2019** R3 The Board should agree the information it requires to support its scrutiny of progress made to deliver all strategic priorities (and supporting actions) set out in the Integrated Medium Term Plan. Information should include as a minimum, progress to date and, where milestones are not met, resulting remedial actions.		Complete The Board has agreed the information need to scrutinise delivery of strategic priorities, and reviews progress on a quarterly basis.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director ofCorporate Governance and Chief of Staff	N/A	Action Closed	n/a	n/a	n/a	n/a	n/a

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External Audit Report - Structured Assessment 2021 (Phase Two) - Corporate Governance and Finanacial Arrangements					Assurance Rating: N/A			Date Received at Audit Committee: 11 January 2022				
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Exhibit 5: progress made on previous year recommendations	Risk management 2016 R7c The Trust should standardise the format of its various risk registers, ensuring the good practice elements of each register are spread across the organisation.		In progress (overdue) The Trust is reviewing all operational risks. Risk registers will be migrated to a new version of DATIX. The Trust has developed a standardised approach to reporting and escalating risks Trust-wide.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** A revised Risk Register template has been agreed via collaboration with Service Leads and the Independent Members of the Audit Committee. The revised template for reporting the risk register will be standadised via the May reporting Governance cycle.		
Exhibit 5: progress made on previous year recommendations	Board assurance and risk management 2019 R2 The Trust should complete the development of its Board Assurance Framework with pace, ensuring that it is appropriately underpinned by up to date risk management arrangements. Specifically, the Trust should • rDeview the principal risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new BAF; • Dpdate the risk management framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; and • Dprovide risk management training to staff and Board members on resulting changes to the risk management framework.		In progress (overdue) The Board Assurance Framework template and key strategic priorities are complete. Key controls and sources of assurance are being developed. The aim is for the Board Assurance Framework to be operationalised in September 2021. Work on the Risk Management Framework and Risk Appetite is complete. Work on operational risks and risk registers is ongoing, with the aim of completion by the September 2021 Board meeting. Risk management training for staff has been developed and due for roll out later in 2021.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director of Corporate Governance and Chief of Staff	November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** TAF is established in a regular cycle of update and submitted through committee and Board cycles. Level 2 and 3 training is complete and level 1 training will be added to learning portfolios on ESR on 17.04.2023. Risk registers continued to be managed in each area of the Trust		

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Exhibit 6: progress made on previous year recommendations	Tracking Internal and External audit recommendations 2018 R4b Implement a mechanism for ensuring that when Internal Audit and External Audit actions are completed, the responsible officer provides a brief summary of the actions taken to the Audit Committee, along with a request to close theaction.		No progress (overdue) No progress has been made on this recommendation.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director ofCorporate Governance and Chief of Staff		Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 7: progress m	Clinical audit scrutiny 2018 R5a The Quality and Safety Committee should review and approve clinical audit plans, ensuring that clinical audit plans address any risks to achieving strategic priorities and organisational risks.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director ofCorporate Governance and Chief of Staff		Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 7: progress made	Clinical audit scrutiny 2018 R5b Improvements should be made to the content of clinical audit reports from both VCC and WBS to clearly identify the audit findings, any associated risks and actions for improvement and follow-up.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director ofCorporate Governance and Chief of Staff		Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 7: prog	Clinical audit scrutiny The Quality and Safety Committee should assure itself that clinical audit findings are addressed.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director ofCorporate Governance and Chief of Staff		Action Closed	n/a	n/a	n/a	n/a	n/a
Exhibit 7: progr	2018 R5d Clinical audit scrutiny The Audit Committee should clarify how it assures itself that the clinical audit function is effective.		To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.	Lauren Fear, Director of Corporate Governance andChief of Staff	Lauren Fear, Director ofCorporate Governance and Chief of Staff		Action Closed	n/a	n/a	n/a	n/a	n/a

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Velindre UNHS Trust

Board Committee Effectiveness 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter arising 1	**Matter arising 1: Cycles of Business and Committee Agendas (Design)** The Trust should: 1.1 a. link the committee cycles of business and agendas to its objectives and risks through: i. cross-referencing with the Trust Assurance Framework (TAF) and Trust Risk Register (TRR) – this should also help to ensure a more streamlined agenda for the QSPC and greater clarity in the Committee's role; ii. consideration of the TAF and TRR during agenda setting, alongside identification of any significant matters arising at the time (for example, the recent issues noted in Radiotherapy); iii. ensuring the running order of, and allocated timing for committee agendas reflects the importance of individual items, potentially with significant matters scheduled earlier in the meeting;	Medium	1.1 a. The TAF/TRR will be cross-referenced with the cycles of business and agendas and will be used during agenda setting. Running orders will reflect the importance of items scheduled for discussion.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** The Trust has developed and reviewed both the Trust Risk Register and Trust Assurance Framework reporting templates via engagement and collaboration with both the Executive Management Team and the Independent Members of the Audit Committee. The revised Risk Register and Trust Assurance Framework reporting templates will support clearer alignment with the Trust's Strategic Objectives and associated risks. The revised templates will be operationalised via the May 2023 Governance reporting cycle. This will now support and underpin utilisation of the Trust Risk and Assurance Frameworks as part of the Board Committee agenda setting process during 2023/24. The Trust Risk Register and Trust Assurance Framework has also been placed at the start of the Main Agenda for each meeting of the Quality, Safety & Performance Committee and as part of the agenda setting process due consideration is given to the running order and prioritisation of significant matters.		
Matter arising 1	1.1 b, include relevant committee sections of the TAF dashboard and TRR at the beginning of all meetings and demonstrate (for example, via the cover report) where key risks are addressed during the meeting;	Medium	1.1 b. Relevant sections of the TAF/TRR will be included at the beginning of all Committee meetings.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** An extract of the the Trust Assurance Framework is reported to each of the Trust Board Committees as required: EMB Shape (whole dashboard), Audit Committee (whole dashboard), Strategic Development Committee (whole dashboard), Trust Board (whole dashboard) and Quality Safety and Performance Committee (dashboard extract). The Trust Risk Register is also received in full at: EMB Shape, Audit Committee, Strategic Development Committee and Trust Board. An extract of the Trust Risk Register is reported to the wider Board Committees as required in accordance with the Trust Board Risk Appetite.		

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Board Committee Effectiveness 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter arising 1	1.1 c. we concur with including the committee cycle of business at the beginning of all meetings and further recommend this be accompanied by a cover report identifying and providing explanations for any departures from the cycle of business;	Medium	1.1 c. A log to capture any deviations from Committee Cycles of Business will be established as part of standard practice across all Board / Committees and matters arising / action logs will track progress against this accordingly.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** Any deviations from the agreed Cycle of Business are captured and reported as standard practice at each meeting of the Quality, Safety & Performance Committee and recorded on the Committee's Cycle of Business. This will also now form standard practice across the wider Board Committee structure.		
Matter arising 1	1.1 d. allow committee members to bring forward items relating to important issues at the beginning of each committee meeting, similarly to when members are asked if they want to move items from the consent agenda to the main agenda; and	Medium	1.1 d. Committee members may bring forward agenda items for earlier discussion if required.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** All Executive Team Members are requested as part of the planning stage for each Board Committee meeting to advise where their respective report needs to be placed in accordance with the Draft Agenda. This is then reviewed and approved at each Agenda Setting Meeting in conjunction with the Board Committee Executive Lead and Chair. Each Executive Team Member is subsequently advised of the agreed running order via issue of the Final agenda. Each Executive Team Member is requested to advise the Committee Secreteriat if there are any required changes to the confirmed running order/agenda in order that the Committee Chair may agree any subsequent changes.		
Matter arising 1	1.1 e. consider calling for and, where appropriate, answering Independent Members' questions in advance of committee meetings to enable more efficient use of time during the meetings (an approach that has proven successful at other NHS Wales organisations);	Medium	1.1 e. We will consider using a 'questions in advance' approach for committee papers.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** The running order of the Consent Agenda has been revised for each of the Board Committee Agendas to follow the Main Agenda to support more efficient use of time during meetings. This is in addition to the established standard practice in place at the start of each meeting where all attendees are invited to request and inform if they have any items they wish to remove from Consent subject to approval by the Committee Chair.		
Matter arising 1	1.1 f. ensure effective use of the Board and committee action logs to capture and present items not on cycles of business at the appropriate meeting and hold individuals to account for providing requested reports; and	Medium	1.1 f. As per above captured under point 1.1 (c)	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** As per above action taken in respect of point 1.1(c).		

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Board Committee Effectiveness 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022				
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Matter	1.1 g. consider whether the NWIS transfer provides opportunity for the Audit Committee to support the cycles of business of other committees.	Medium	1.1 g. Consideration will be given to whether the NWIS transfer has provided opportunity for the Audit Committee to support the cycles of business of other committees.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** A review of the running order and prioritisation of the Trust Audit Committee agenda at each meeting has been undertaken and agreed with the Audit Committee Chair effective April 2023. The benefit realisation of this will be reviewed to assess whether through the more efficient use of time measures outlined above captured within this process will support and enable the Audit Committee aspects of the other Committee Cycles of Business; however this will need to be assessed in accordance with the agreed remit and responsibilities of each of the Board Committees and associated Terms of Reference.		
Matter arising 3	**Matter arising 3: Committee Reporting (Design)** 3.1 The Trust should develop a quality assurance mechanism for committee reports, including: a. communicating with report writers for each committee meeting to make them aware of the audience, the purpose of the required reports and the level of detail that will be required; and	Low	3.1 a. Report authors will be informed of the purpose of committee reports and the level of detail required.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** Report writing training has been provided across the Trust 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.		
Matter arising 3	3.1 b. reviewing reports in advance of issue to Independent Members to verify that they address the report purpose, include a succinct executive summary identifying key matters for escalation and assurance and contain an appropriate level of detail.	Low	3.1 b. A mechanism to review reports in advance of issue will be developed to ensure the points in recommendation 3.1 (b).	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** Each of the Trust Executive Leads is accountable and responsible for formally approving the reports in advance of receipt by the Committee as per action 3.1(a) In addition, a review of the Cover Paper report template for Board Committee reports has been undertaken across the Trust in conjunction with the Trust Board to support this recommendation. The revised template also now includes an Executive Summary section to include key matters for escalation and assurance. This will be utilised across the Trust via the May governance reporting cycle.		
Matter arising 4	**Matter arising 4: Gaps or Duplication in Reporting (Design)** 4.1 The Trust should: a. review and clearly define the RDISC reporting lines to minimise the risk of gaps or duplication in reporting; and	Low	4.1 a. The RDISC reporting lines will be reviewed and defined to minimise the risk of gaps or duplication.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** As per action taken in respect of point 4.1(b).		

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Board Committee Effectiveness 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022				
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Matter arising 4	4.1 b. provide clarity on the purpose for reporting where a subject matter is reported to more than one committee, ensuring reports are tailored according to the audience and purpose.	Low	4.1 b. Clarity will be provided on the purpose for reporting where a subject matter is reported to more than one committee.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** The revised Cover report template for the Trust Board Committees as outlined above in 3.1(b) also now incorporates a brief summary and outcome of previous governance discussions where if the report has been previously considered at another meeting it will include a high level overview of the outcome of the considerations and discussion, including any impact on the Trust's Strategic Risks/Operational Risks and what actions are required to address this. This section will have a strict word limit to also help support and avoid scope for duplication.		
Matter arising 5	**Matter arising 5: Timeliness of Committee Paper Availability (Operation)** 5.1 The Trust should: a. remind staff reporting into the committees of the importance of timely submission of their reports; and	Low	5.1 a. Staff will be reminded of the importance of timely submission of committee reports.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** Deadlines are reinforced as part of the standard process for calling for report papers. Each of the Executive Leads is accountable for ensuring that these are adhered to. Any late paper submission deadlines are to be strictly reinforced and subject to formal agreement with both the Committee Executive Lead and then subsequently Committee Chair for implementation through the 2023-24 reporting cycle onwards.		
Matter arising 5	5.1 b. monitor delays in the lateness of delivery of papers and provide challenge where appropriate.	Low	5.2 b. The Corporate Governance team will monitor delays in the lateness of delivery of papers and provide challenge where appropriate.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** As per action taken in respect of point 5.1(a). This process will also be reflected in the Corporate Governance Manual.		
Matter arising 6	**Matter arising 6: Record of meetings (Operation)** 6.1 The Trust should accurately record those present at committee meetings in the minutes, including the status in which individuals attend.	Low	6.1 Management will ensure committee minutes accurately record those present at meetings, including the status of individuals in attendance.	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	April 2022 November 2022 out of Committee Extension agreed: 31 March 2023. (Link to updated Governance Manual completion)	Complete			**Complete.** Board Committee attendance recorded and captured in the respective minutes is subject to review as part of the established approval process by the Board Committee: Corporate Governance Lead, Executive Lead and Chair. The Draft minutes are subsequently confirmed at each Board Committee meeting to confirm if there are any points/matters of accuracy. Any amendments requested are then actioned if required as appropriate.		

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Trust Assurance Framework 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 11 January 2022				
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Matter arising 2	**Matter arising 2: Operational risk reporting (TRR) (Operation)** 2.1 The Trust should: a. ensure the review and refinement of the risks on the TRR is completed as planned by the end of March 2021; and	Medium	2.1 a. To complete, taking into account current service pressures, still aim for March, given medium priority	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	March 2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Matter arising 2	2.1 b. update the Risk Management Framework process documentation to provide a monthly timetable of actions for departments/divisions/projects to adhere to when updating and reporting risk, and that a definitive list of which departments, divisions and particularly projects are required to review their Datix risk records and report to the Corporate Governance Team monthly.	Medium	2.1 b. To complete	Lauren Fear, Director of Corporate Governance & Chief of Staff	Lauren Fear, Director of Corporate Governance & Chief of Staff	March 2022 November 2022 out of Committee Extension agreed: 31 January 2023.	Complete			**Complete.** New Risk Policy was approved by Trust Board and is now available on the intranet via the following link: https://nhswales365.sharepoint.com/:w:/r/sites/VEL_Intranet/_layouts/15/Doc.aspx?sourcedoc=%7BD3532D8B-B22C-4DD8-B000-CBA61A493737%7D&file=FINAL%20-%20VUNHST%20Risk%20Management%20Policy%20-%20APPROVED%20AT%20TB%2029.09.2022.docx&_DSL=1&action=default&mobileredirect=true Risk Management Prodcedure has been developed and signed off and is now available on the Trust Intranet via the following link: https://nhswales365.sharepoint.com/:w:/r/sites/VEL_Intranet/_layouts/15/Doc.aspx?sourcedoc=%7B50651980-FA3F-43C1-B62C-918CD513FA72%7D&file=RISK%20MANAGEMENT%20PROCEDURE.docx&_DSL=1&action=default&mobileredirect=true		

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High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

nVCC MIM Governance 2021/22					Assurance Rating: Substantial			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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter Arising 1	**Matter Arising 1: Effectiveness of Governance Arrangements (Operation)** 1.1 Recognising the external pressures of the project, matters for decision making should be taken to the appropriate forum in a timely manner to help manage stakeholder expectations.	Medium	1.1 Noted. The Project will endeavour to ensure that matters for decision making are taken through the appropriate forum and documented for audit purposes.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials) in conjunction with the responsible reporting officer and Communications team.	Immediately	Overdue				These recommendations have yet to be followed up. Validation of management actions is included within the Integrated Audit Plan but timing of this work has yet to be confirmed.	
Matter Arising 1	1.2 Papers presented to Project Board for endorsement / approval should be full, complete and appropriately referenced to assist in a timely decision-making process	Medium	1.2 Noted. The Project will ensure that all reports for endorsement / approval are full, complete and appropriately referenced.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials) in conjunction with the responsible reporting officer.	Immediately	Overdue				These recommendations have yet to be followed up. Validation of management actions is included within the Integrated Audit Plan but timing of this work has yet to be confirmed.	

Audit Action Plan

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

nVCC Contract Management 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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter Arising 1	**Matter Arising 1: Contract Documentation (Operation)** 1.1 The appointment process should be managed to ensure accuracy of the information reported to management i.e. contract value and timing of evaluation / acceptance.	Medium	1.1 Noted. The Project will improve the management of the contractor appointment process by implementing a quality assurance process that signs off contract documentation.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials).	Immediately	Complete	**Update on New Velindre Cancer Centre Development: Contract Management Audit Report January 2023 Audit Committee (Follow up of previous recommendations previous MA 1.1).** **Current Findings:** Recognising fovcus on the MIM Priorities, this has not yet been progressed. Noting wider contract management issues identified at this year's audit, the appointment process should now be considered in conjunction with the new recommendation made. Conclusion: Superseded. See MA1, Appendix A.	n/a	n/a	n/a	n/a
Matter Arising 1	1.2 Contract documentation should be signed in a timely manner and prior to the commencement of works.	Medium	1.2 Noted. The Project has improved processes to improve the timeliness of signing contract documentation to ensure that all documentation is signed within 30 days.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials).	Immediately	Complete	**Update on New Velindre Cancer Centre Development: Contract Management Audit Report January 2023 Audit Committee (Follow up of previous recommendations previous MA 1.2).** **Current findings:** At the 10 contracts reviewed this year's audit, contracts were only in place prior to commencement of duties in two cases. Of the eight completed after commencement, none met the 30-day timeframe as per the management response (with a number remaining outstanding at the time of fieldwork, recognising Board approvals had been required). The difficulties in acheiving proactive contract execution, in some of the cases reviewed this year, are recognised. Conclusion: Superseeded. See MA1, Appendix A.	n/a	n/a	n/a	n/a
Matter Arising 2	**Matter Arising 2: Appointment Process (Operation)** 2.1 The procurement exercises, which have been ongoing since April 2021, should be finalised as soon as possible.	Medium	2.1 The Project has now concluded all appointments of TA's for the nVCC Project; and appointed Technical Project Manager and Cost Consultants.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials).	Actioned since fieldwork	Complete			**Complete.** The procurement exercises, have been finalised. The Project has now concluded all appointments of TA's for the nVCC Project; and appointed Technical Project Manager and Cost Consultants.		

Audit Action Plan

Velindre UNHS Trust

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

* Unless a more appropriate timescale is identified / agreed

nVCC Contract Management 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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter Arising 3	**Matter Arising 3: Contractor Performance and Key Performance Indicators (Operation)** 3.1 Reporting on contractor performance and Key Performance Indicators should be undertaken in line with expectation.	Medium	3.1 Noted. The Project will ensure that balanced scorecards for appropriate contractors will be reported to the Project Board on a quarterly basis.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials).	Immediately	Complete	**Update on New Velindre Cancer Centre Development: Contract Management Audit Report January 2023 Audit Committee (Follow up of previous recommendations previous MA 3.1).** **Current Findings:** Recognising focus on the MIM priorities, this has not yet been progressed. Noting wider contract management issues identified at this year's audit, the expectations for reporting should now be considered in conjunction with the new recommendation made. Conclusion: Superseded. See MA1, Appendix A.	n/a	n/a	n/a	n/a

Audit Action Plan

Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - management action not complete

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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter arising 1	**Matter arising 1: Late payment of invoices (Operation)** 1.1 The Trust should: a. investigate why these BT invoices are being paid late, liaising with NWSSP Accounts Payable where necessary;	Medium	1.1 a. The recommendation is accepted. Investigation confirmed as part of the audit that the NWSSP Accounts Payable team held and delayed processing	Matthew Bunce, Executive Director of Finance	N/A	Complete	Action Closed	n/a	n/a	n/a	n/a	n/a
Matter arising 1	1.1 The Trust should: b. liaise with NWSSP Procurement Services and Accounts Payable to understand: i. why such late fees are being charged by BT; and why they have signed agreements that they cannot deliver on; ii. how late fees are accounted for (i.e., are they coded to an appropriate loss account in Oracle); and iii. what the wider performance monitoring and accountability mechanisms are to ensure invoices are paid by their due dates (when this is less than 30 days) and to monitor the level of late payment fees 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 Committee Extension agreed: 31 December 2022. Extension Agreed January 2023 Audit Committee: August 2023.	On Target	SIP circuit migration under way within the digital team. On course to be completed within the revised timeline. In meantime finance department exploring option to pay BT invoices by credit card to try and improve performance and reduce charges.	SIP Circuit expect to implemented by end of March which will remove the BT invoicing.	SIP circiut was procured as part of year end Capital Spend. Go live date expected by May 23.		12 months
Matter arising 2	Matter arising 2: Exception reporting (Operation) 2.1 The Finance team should: a. undertake a formal, documented monthly review of the exception reports, even if no specific matters are identified through the informal weekly reviews;	Medium	2.1 a. The recommendation is accepted. The Divisions will undertake a more formal review which will be signed off by a senior finance business partner. The review will be put in place by the target date.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Financial Planning & Reporting Manager	31/03/2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Matter arising 2	2.1 The Finance team should: b. take action to address the aged items on the exception reports; and	Medium	2.1 b. The recommendation is accepted. Discussion will take place amongst the Senior Finance Team to agree action to be taken on aged invoices to address the immediate issue and long-term approach which will form part of the review process under item2.1.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
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
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

Audit Action Plan

Velindre UNHS Trust

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Medium	< 1 month *
High	Immediate *

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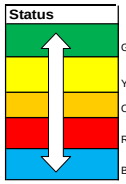
Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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
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;		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
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
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 developedforproforma invoices.	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
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
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
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 Committee Extension agreed: 26 January 2023.	Overdue		FCP still currently on hold until TOR are agreed for the new Capital Strategic Board to understand what the remit will be of the Capital Planning Group. The first meeting of the strategic Capital Board is in April so aan extension request is requested until May to allow time to agree TOR and update FCP accordingly.	FCP still currently on hold until TOR are agreed for the new Capital Strategic Board to understand what the remit will be of the Capital Planning Group. The first meeting of the strategic Capital Board is in April so an extension request is requested until July to allow time to agree TOR and update FCP accordingly and allow for correct governance approval.	31 July 2023	14 months

Audit Action Plan



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Priority	
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Medium	< 1 month *
High	Immediate *

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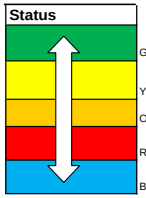
Velindre UNHS Trust

Financial Systems - 2021/2022 Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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
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	n/a
Previous Matter arising	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.		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		n/a	n/a	n/a	n/a	n/a
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	n/a
Previous Matter arising 2	c. The Trust should ensure the SOP for Private Patients unallocated and unidentified receipts is approved at an appropriate forum (e.g., by the Audit Committee).	Medium	c. The recommendation is accepted. A Departmental SOP has been drafted for the management of unallocated and unidentified receipts, with significant work undertaken to date resulting in a reduction in the reported aged debt position. The SOP will be submitted for approval to the Audit Committee.	Cath O'Brien, Chief Operating Officer	Ann-Marie Stockdale, Head of Outpatients, Medical Records and Private Patient Service	30/04/2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Previous Matter arising 3	Previous matter arising 3: Management of Aged Debts (Operating effectiveness) 3.1 We concur with the Trust's continued focus on general and charity aged debts. We further recommend: a. Charity debts: the Trust should formally review its processes for charity invoicing and debt collection, both internally between finance and the divisions and through discussions with relevant charities (particularly Macmillan and Marie Curie) to identify inefficiencies within the process;	Low	3.1 a. The recommendation is accepted. Increased frequency of liaison and enhanced formal processes will be put in place both internally and with partners	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Finance Business Partnering	31/03/2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Previous Matter arising 3	3.1. b. General debts: the Trust should consider identifying and monitoring formal key performance indicators with clear targets for general debts, similar to those set out in recommendation 1.1(b) of prior year recommendation 1.	Low	b. The recommendation is accepted. Consideration will be given to identifying and monitoring formal key performance indicators with clear targets for general debts.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022 Complete but request to keep action open until **October 2022 meeting** to allow review	Action Closed	n/a	n/a	n/a	Update October 2022: Complete. Action should have been marked as complete for October 2022 Audit Committee.	n/a

Audit Action Plan



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

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Velindre UNHS Trust

Scrutiny of Expenditure >£100k 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matther arising 1	Matter arising 1: Proposals Documentation (Design and Operation) 1.1 a. The Trust should enhance the user guidance for the proposal forms, including, but not limited to the following: • determine the minimum number of options that should be included in a proposal (including "do nothing option"); • additional guidanceon: - risk identification and analysis; - benefits identification and measurements; • the requirement to provide supporting justification for the procurement route, particularly if a less preferred option (e.g., Single Tender Action) is proposed; • clarify the approval route for proposals submitted by corporate (as opposed to divisional) teams;	Medium	1.1a The guidance will be enhanced further to: - specify the minimum number of options required inclusive of the 'do-nothing' option - provide additional guidance / expectations on risk identification and analysis - include the requirement to provide supporting justification of the procurement route - clarify the corporate approval routes.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022 Complete	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 1	1.1 b. The Trust should share the learning identified throughout this audit with those responsible for completing and scrutinising proposals via the established mechanisms for regular and ongoing engagement with service leads in place	Medium	1.1b Management has already shared the high-level findings with the key service leads to support continued development and enhancement of the process. This will be disseminated further through the established local mechanisms once the final report is confirmed.	Matthew Bunce, Executive Director of Finance		Complete	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 1	1.2 Furthermore, we suggest that all proposal documentation should include details of future monitoring to be completed at a divisional level.	Low	1.2 The guidance will be enhanced to require details of any planned future monitoring arrangements proportionate to the scheme proposal.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 1	1.3 The Trust should consider maintaining a register of proposals for expenditure above £100,000 to monitor the type of proposals being made (e.g., proactive / reactive proposals, what areas they relate to etc…). This will enable the Trust to identify any trends / recurring issues and take appropriate proactive action to address them.	Low	1.3 Management will consider the development of register of proposals to support future monitoring of expenditure.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	n/a	n/a	n/a	n/a	n/a

Audit Action Plan

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Scrutiny of Expenditure >£100k 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022				
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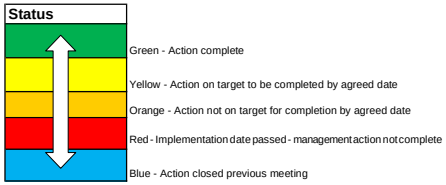
Matther arising 2	Matter arising 2: Pre-Board Scrutiny Evidence (Design) 2.1 We recommend that: a. the proposal guidance should reinforce the need to fully complete all sections of the proposal prior to submission to EMB and Trust Board;	Medium	2.1 a. The guidance will be enhanced further to reinforce the need to fully complete all sections of the proposal prior to the submission to EMB and Trust Board. This is supported by feedback and engagement with service leads that has already taken place on a regular basis since the new scrutiny process was established to support its continued development.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 2	2.1 b. the scrutiny role and responsibilities of the forums should be clearly defined in the proposal guidance, including that the scrutiny process should assess the quality of information against the guidance requirements;	Medium	2.1 b. The guidance will be enhanced further to outline the scrutiny role and responsibilities of the assessing forums i.e. they are required to review all aspects of the form for completeness, accuracy and quality of information provided.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 2	2.1 c. meeting minutes (or equivalent) should clearly demonstrate that scrutiny and discussions were undertaken over each proposal;	Medium	2.1 c. Separate guidance / information will be provided to the relevant meeting secretariat within the divisions to specify the exact requirements and expectations for documenting any discussion and scrutiny applied of the scheme proposals. This is already in place for corporate services.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 2	2.1 d. the proposal guidance should include the process for fast-track approval (e.g., an out of committee approval) and the supporting audit trail required to evidence scrutiny and approval of such proposals. The proposal documentation should also be clear that an out of committee approval approach was used.	Medium	2.1 d. The guidance will be enhanced to include reference to the agreed out of committee approval process / arrangements in place.	Matthew Bunce, Executive Director of Finance	Emma Stephens, Head of Corporate Governance	31/05/2022 November 2022 out of Committee Extension agreed: 31 December 2022.	Complete			The guidance has now been updated to incorporate the out of committee approval process (flow chart to support effective implementation across the Trust)	n/a	n/a

Audit Action Plan



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

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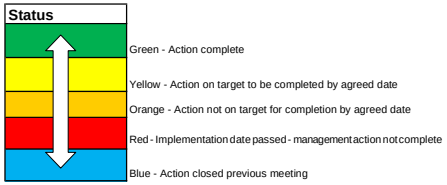
Velindre UNHS Trust

DBS Check 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matther arising 1	Matter arising 1: Job Descriptions (JDs) (Design) 1.1 The Trust should implement a robust mechanism for ensuring the quality of JDs prior to advertisement, including ensuring appropriate DBS check requirements are included. This could be through a requirement that Workforce reviews all JDs prior to advertisement, or through Workforce spot checks to identify areas where further advice, guidance or support for recruiting managers may be needed.	Medium	1.1 i. As part of the Attraction, Recruitment and Retention Group for the Trust, a task and finish group will be set up to streamline processes and ensure all documentation is relevant and with the correct responsible persons. One specific objective of the Task and Finish group will be to review the current process for writing Job Descriptions, including a manager's guide for ensuring the appropriate information is included and DBS requirements are correctly noted. Action: Review current process for writing job descriptions and develop a manager's guide.	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce	Oct 2022 November 2022 out of Committee Extension agreed: 31/12/2022 The All Wales project group have not been set a specific timeline for achieving this work however the task and finish group are in a position to feedback updates to the Recruitment Modernisation Board for November 2022	Complete			**Closed** - New Job Decrtiption and managers guide to wiritng JD's implemented in the Trust. These are now live. Comms to recrutiming managers has been sent and Intranet pages updated		
Matther arising 1		Medium	1.1 ii. A second written standard operating procedure will be written to add DBS quality check within Job Evaluation process. This will ensure Job Descriptions have correctly identified the DBS requirement of the role during the quality assurance checking stage before job descriptions are signed off for recruitment. Action: Write a standard operating procedure to add the DBS quality check to the Job Evaluation process.	Sarah Morley, Director of OD and Workforce	Judy Stafford Workforce Manager (Job Evaluation Lead)	Jun-22	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 2	Matter arising 2: Trust Recruitment and DBS Policy / Procedure (Design) 2.1 The Trust should: a. develop its local policy / procedure for recruitment (including DBS checks) as a matter of priority, considering the points raised in our finding and the requirements of the DBS Code of Practice;	Medium	2.1 a. (i) The DBS project group recommended the development of a DBS policy as part of next steps in December 2021 and, because development of the policy was not completed within the original anticipated timeframe, included this on the Safeguarding Risk Register. A draft policy is already in development following this recommendation. Action: Complete the development of the DBS Policy	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce / Tina Jenkins, Senior Nurse Safeguarding & Public Protection	Sept 2022 November 2022 out of Committee Extension agreed: January 2023 (Documents completed - this is now based on the cycle of business for the Trust's governance meetins to approve the policy)	Complete			**Complete.** Recrutiment Policy and DBS proceedure approved in January 2023		
Matther arising 2		Medium	2.1 a. (ii) The Trust's Attraction, Recruitment and Retention Group will consider the development of the Trust's Recruitment Policy. This is a wider project that needs to encompass the ongoing work on Talent Management, Organisational Values, Workforce Planning, Education Commissioning and Student Streamlining and have involvement from key stakeholders in the process. Action: Develop a Trust Recruitment Policy	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce	Apr-23	Action Closed	n/a	n/a	n/a	n/a	n/a

Audit Action Plan

Velindre UNHS Trust

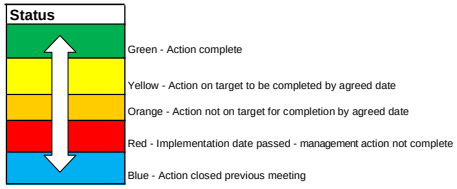


Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

DBS Check 2021/22					Assurance Rating: Reasonable			Date Received at Audit Committee: 03 May 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matther arising 2	2.1 b. ensure the policy / procedure is communicated to all relevant staff and is made available on the intranet; and	Medium	2.1 b. The Trust's intranet is currently under development and the previous cascade system will end in June 2022. It is expected the next intranet will be available to staff from July 2022 and the Workforce and OD page will include all policies and procedures. Action: Communicate DBS policy to staff via staff communications and intranet.	Sarah Morley, Director of OD and Workforce	Victoria Davies Project Manager – Workforce Planning	Jul 22 Extension Requested September 2022 November 2022 out of Committee Extension agreed: January 2023 This will be communicated and uploaded to the Trust's WOD policies and procedures page when approved. Communicated viw the news bulletins on SharePoint and through SMT/SLT	Complete			**Completed.** The policy and supporting documents were approved in January 2023 and are available on the Trust Intranet. Recruiting managers have also targeted comms on the new documentation (Policy / JD / guides etc.)		
Matther arising 2	2.1 c. put in place a mechanism to monitor compliance with the Trust's new policy.	Medium	2.1 c. Alongside the development of a new policy, toolkits, guidance and standard operating procedures will be developed, hence the need for engagement from all stakeholders in the process. Action: Standard operating procedure for the monitoring of compliance with the DBS Policy.	Sarah Morley, Director of OD and Workforce	Amanda Jenkins, Head of Workforce	Jul 22 Extension Requested September 2022 November 2022 out of Committee Extension agreed: December 2022 Written control documents not policy specific can be approved by EMB so these will be completed before	Complete			**Completed.** The policy and supporting documents were approved in January 2023 and are available on the Trust Intranet. Recruiting managers have also targeted comms on the new documentation (Policy / JD / guides etc.)		
Matther arising 3	Matter arising 3: Out of Date Countersignatory (Operating effectiveness) 3.1 The Trust should update its DBS countersignatories and ensure this remains up to date in the future.	Low	3.1 Action: The Trust will contact DBS to update countersignatories for the Trust.	Sarah Morley, Director of OD and Workforce	Sarah Morley, Director of OD and Workforce	May-22	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 4	Matter arising 4: Backlog in NWSSP Completion of Personnel Files (Operating effectiveness) 4.1 The Trust should: a. monitor NWSSP's resolution of the backlog to ensure this is undertaken on a timely basis; and	Low	4.1 a. Workforce team will continue to track and monitor the files from the backlog of NWSSP files. As of 07th April 2022 it was identified this has reduced from 61 outstanding to 20 outstanding. NWSSP will send outstanding files to managers and contracts to employees. Action: Outstanding personal files to be sent to managers.	Sarah Morley, Director of OD and Workforce	Judy Stafford Workforce Manager (with support from NWSSP Recruitment Services)	Sep-22	Action Closed	n/a	n/a	n/a	n/a	n/a
Matther arising 4	4.1 b. formally document the process carried out by the Workforce team to check that appropriate pre-employment checks are completed by NWSSP.	Low	b. Action: A standard operating procedure will be written for monthly checks of new starter files undertaken within the workforce team.	Sarah Morley, Director of OD and Workforce	Judy Stafford Workforce Manager	Jun-22	Action Closed	n/a	n/a	n/a	n/a	n/a

Audit Action Plan



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

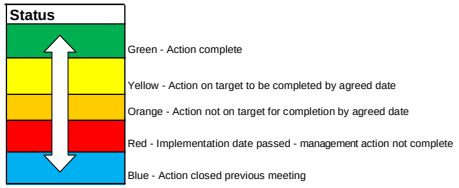
* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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 Committee 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 extension requested in February updated to allow CEO to review scheme of delegation before submission to the CFC.	Overdue	Final policy is on course to be submittted to March CFC committee for approval. Extension previously requested to March in line with ability to approve delegation approval and update policy.	Per previous update the revised Scheme of delegation paper was shared at the Charity SLG meeting in November however, in the absence of the CEO a recommendation could not be made to the Charitable funds committee. The paper was subsequently shared with the Chief Executive and DoF on 7th December for review prior to inclusion in the policy. However, the Chief Executive wants to review and discuss the proposals and seek agreement through the CFC SLG so an extension of a further 3 months to the action deadline is requested. In the meantime the current policy remains fit for purpose while a review of the scheme of delegation is undertaken.	February update remains where an extension to the end of June is required which is the date of the next CFC. This gives the chief executive opportunity to review and agree to the updated scheme of delegation.	30 June 2023 (For one of the three Policies). (Two of the three polices have been approved).	8 months
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
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
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

Audit Action Plan

Velindre UNHS Trust



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

* Unless a more appropriate timescale is identified / agreed

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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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
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
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
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
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
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
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

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

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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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
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	Action Closed	n/a	n/a	n/a	n/a	n/a
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
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

Audit Action Plan

Green - Action complete

Yellow - Action on target to be completed by agreed date

Orange - Action not on target for completion by agreed date

Red - Implementation date passed - management action not complete

Blue - Action closed previous meeting

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

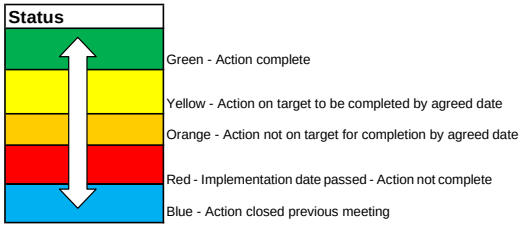
* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

External Audit Report - Taking Care of the Carers?					Assurance Rating: N/A			Date Received at Audit Committee: 03 May 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022
R1	**Retaining a strong focus on staff wellbeing** NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.		VUNHST implemented the COVID risk assessment tool from 2020 onwards and it is available to all staff through their ESR employee self-service. This is very easy for staff to access. Managers are encouraged to review COVID risks as part of normal line management as part of regular one to one meetings, Performance Appraisal and Development Review (PADR) discussions and wellbeing conversations. Staff who are identified as being vulnerable have been supported to continue working, through utilising remote working to its full extent and organising work to reduce personal contacts. The Trust has a Healthy and Engaged Steering Group that	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Action Closed	Complete on May 2022 Audit Committee Report	n/a	n/a
R2	Considering workforce issues in recovery plans NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.		The Trust has a strategic plan supported by a suite of enabling strategies, including a People Strategy. The People Strategy has Wellbeing as one of the six themes for the Trust. This has made the link between the wellbeing of staff and capacity and capability to deliver services. The Trust Integrated Medium Term Plan for 2022-23 sets out workforce activity in line with the People Strategy and as such includes a section on staff wellbeing. The Inspire management development programme	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Action Closed	Complete on May 2022 Audit Committee Report	n/a	n/a

External Audit Report - Taking Care of the Carers?					Assurance Rating: N/A			Date Received at Audit Committee: 03 May 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022
R3	Evaluating the effectiveness and impact of the staff wellbeing offer NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.		Throughout the pandemic the Trust has maintained open dialogue with staff using listening events and other sessions. For example, there was a Staff Wellbeing during COVID event open to all staff on MS Teams on 3 February 2022. Feedback was gathered here on what worked well/not so well and how staff's wellbeing had been affected by COVID. to inform the next steps of support for staff and to shape ideas for Agileworking. Data on the usage of the Employee Assistance Programme is analysed quarterly to identify themes or issues. The Trust is recruiting a Clinical Psychologist for Staff and Teams. Once in post, this person will work with the Workforce and OD team to evaluate services, programme and initiatives and make informed decisions about what to provide.	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Jun-22	Action Complete	N/A	The Healthy and Engaged Steering Group commissioned a review of the effectiveness of our wellbeing offer through Audit services in July 2022. The findings and recommendations will be reported to the Executive Director of OD and Workforce on 26 August 2022 and these will inform our next steps in developing our wellbeing offer. Quarterly reports on the use of the Employee Assistance Programme are being recieved and used to inform future provision of support. The Staff Psycholgoist has been appointed and will start on 5 September 2022.	The Advisory Audit Report has been completed and will be prsented to October Audit Committee. The recommendations will be adopted by the Healthy and Engaged Steering Group at its October meeting and the Trust work programme will be amended accondingly. Actions will then be monitored via the HESG.
R4	Enhancing collaborative approaches to supporting staff wellbeing NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.		The Trust is an active member of the HEIW Health and Wellbeing Network and is contributing to the development of national resources to support health and wellbeing. The Trust has an Employee Assistance Programme for staff. This provides services to enhance emotional wellbeing including counselling and	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Action Closed	Complete on May 2022 Audit Committee Report	n/a	n/a
R 5	Providing continued assurance to boards and committees NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.		The Trust Assurance Framework has a risk relating to organisational culture and a key control specified is that the Health and Wellbeing of the Organisation is to bemanaged – with a clear plan to support the physical and psychological wellbeing of staff. The Trust holds Platinum Status in the Corporate Health Standard which recognise significant achievements in the Trust relating to health and wellbeing of staff and for its work on sustainable development and corporate social responsibility.	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Action Closed	Complete on May 2022 Audit Committee Report	n/a	n/a
R 6	Building on local and national staff engagement arrangements NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.		The Trust has an open approach to engaging with staff and provides listening events and focus groups on a regular basis. The Local Partnership Forum meets quarterly with management to raise issues employee issues, including health and wellbeing. The Trust's Diversity Networks will be further developed in 2022 further enhancing this clear route for their feedback to be taken intoaccount. The Trust will be encouraging use of its on-line platform, Work in Confidence, which offers staff a way to raise concerns in confidence. This will further develop a culture of trust where people feel able to raise important issues that maybe	Sarah Morley, Director of OD and Workforce	Susan Thomas, Deputy Director of OD and Workforce	Completed	Action Closed	Complete on May 2022 Audit Committee Report	n/a	n/a

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

nVCC Financial Reporting 2021/22					Assurance Rating: Substantial			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update for July 2022 Committee	Update August 2022	Update September 2022
Matter Arising 1	1.1 The finance reports should present consistent and up to date information regarding revenue funding.	Low	1.1 Agreed. The finance reports will be checked, before presentation, by the Assistant Project Director (Finance & Commercials) to ensure consistency of reported figures and to have no transposition errors.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jun-22	Action Closed	Completed in June 2022	Complete on July 2022 Audit Committee Report	n/a
Matter Arising 1	2.1 Narrative and financial information should be finalised for the separate Project Progress Reports (nVCC and EW projects) for the next submission to Welsh Government.	Medium	2.1 Agreed. The WG Project Progress Reports will include all the relevant narrative and financial information relating to the specific project. Separate Project Progress Reports, for May 2022, were submitted for the nVCC and EW Projects.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jun-22	Action Closed	Completed in June 2022	Complete on July 2022 Audit Committee Report	n/a
Matter Arising 1	2.2 Figures reported to Welsh Government should align with those reported, internally, in the finance reports, and vice versa.	Low	2.2 Agreed. As per 1.1, the finance reports will be checked, before presentation, by the Assistant Project Director (Finance & Commercials) to ensure consistency of reported figures and to have no transposition errors.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jun-22	Action Closed	Completed in June 2022	Complete on July 2022 Audit Committee Report	n/a

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

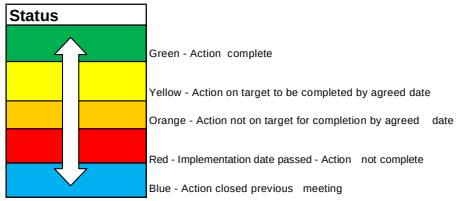
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

nVCC Enabling Works Security Contract					Advisory Report			Date Received at Audit Committee: 19 July 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	
Matter Arising 1	4.1 The Single Tender Action for the security arrangements on the advanced works should be reported to the Audit Committee		4.1 The Assistant Project Director (Finance & Commercials) will liaise with the Director of Finance to ensure that the STA is reported to the Audit Committee in July 2022.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jul-22		
Matter Arising 2	4.2 Contracts should be in place before duties/works commence. The contract documentation pertaining to the security arrangements for March 2022 should be addressed by all parties		4.2 The Enabling Works Project Manager(s) need to ensure that appropriate approvals are sought, and contracts varied where needed, if activities go beyond a contract end date. The approvals need to be in writing so that contract variations can be actioned. Failure to obtain approvals will be addressed using the normal Trust performance procedure.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Ongoing Process		
Matter Arising 3	4.3 Purchase orders should reconcile with the approved contract sum.		4.3 The Assistant Project Director (Finance & Commercials) will ensure that the Project Contracts Team have purchase orders for approved contract sums. The Project Finance Team will reconcile the purchase orders on a monthly basis.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Ongoing Monthly Process		
Matter Arising 4	4.4 Board approval is required for the increase to the purchase order value relating to the security provision for the tree clearance works. Prior to this, a full review of variations to contract should be undertaken, in conjunction with the Security Manager, to confirm accuracy of the additional costs incurred.		4.4 The Project Finance Team and the Enabling Works Senior Project Manager have completed a review of the contract variations to confirm the accuracy of the additional costs incurred. A Board report has been prepared to obtain approval for the increase in costs. It has been endorsed for Board approval by the Enabling Works Project Board and it is expected to be presented to the July Trust Board.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jul-22		
Matter Arising 5	4.5 Changes to base contract details should follow a formal change management procedure. All changes should be documented, costed, approved accordingly, and reported to an appropriate forum, to further facilitate appropriate financial management of the approved contract.		4.5 The Enabling Works Project Manager(s) need to ensure that appropriate changes to base contract details follow the Project's formal change management procedure. The Project Finance Team will cost any such changes. The approvals of the changes to base contracts will be undertaken in accordance with the Trusts delegated limits process. The changes to base contracts will be reported to the Enabling Works Project Board.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Ongoing Process		
Matter Arising 6	4.6 Management should undertake a 'lessons learned' exercise regarding the requirements/expectations of security provision, noting the current procurement exercise for security resource at the next stage of the Enabling Works programme. Management comment:		4.6 The Assistant Project Director (Finance & Commercials) will undertake a lessons learned exercise with the Enabling Works Project Team in July 2022.	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	Jul-22		

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Wellbeing of Future Generations Act					Advisory Report			Date Received at Audit Committee: 19 July 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	
Recommendation 1	When an agile approach is used, the Trust may wish to consider, and identify up front, the level of evidence needed to demonstrate the process and support the actions taken. Examples include maintaining a list of meeting dates (identifying the meeting purpose), retaining informal meeting notes, and maintaining an action log.		Conclusion: The Trust used an agile approach to developing its overarching and enabling strategies, with clearly identified strategy leads, outputs and an indicative timeline. The joined-up approach supported the threading of common themes throughout the strategies, underpinned by the principles of the FGA. Engagement was undertaken with staff, the public and other stakeholders and was taken seriously by the Trust; changes made to the Trust Strategy as a result. Progress on strategy development has been regularly reported to the Strategic Development Committee.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation 2	Where not yet set, the Trust should ensure clear targets and milestones for the performance indicators identified in the Sustainability Strategy are clearly defined in the tactical implementation plans.			Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation 3	a. The Trust may wish to undertake a wider self-assessment of its baseline position against the FGA. The AW positive indicators and FGC Trackers can be used to support this process, recognising these tools are neither prescriptive nor exhaustive, therefore the Trust may be taking actions not included in either whilst still contributing to the seven wellbeing goals and implementing the SDP.		Conclusion: The Trust is demonstrating a clear commitment to embedding the SDP and 5 ways of working. Whilst it can demonstrate contribution to the wellbeing goals and application of the SDP in places, the Trust acknowledges it is not yet at a point where this is consistently embedded into the organisation's ways of working and decision making. Recommendations made throughout this report aim to support the Trust on its FGA journey.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		

Audit Action Plan

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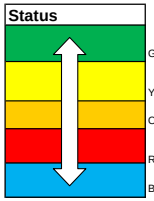

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Wellbeing of Future Generations Act					Advisory Report			Date Received at Audit Committee: 19 July 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	
Recommendation 3	b. As part of the self-assessment process, the Trust should consider undertaking analysis to identify its current sustainability culture to support development of effective actions to enhance its current position. See Appendix Six for guidance on how this could be carried out.			Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation 4	a. The Trust may wish to consider whether increased focus on the FGA and sustainability at an Executive or senior management level would be beneficial in supporting its FGA journey.		Ideas identified through other NHS Wales organisations • Embedding Sustainability to Corporate Thinking and Decision-making through inclusion of sustainability risks in Board papers.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation 4	b. In reviewing the job description of the Estates Development Officer, the Trust should consider what other NHS Wales organisations have in place in terms of operational leadership and support.			Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation 5	Whichever forum the Trust decides to use to provide oversight, accountability and leadership for the FGA, it should consider including finance and communications representation in the membership: • Finance representation: to support the Trust's goal to triangulate performance reporting and to consider the impact sustainability has on finance and the need to ensure financial sustainability; and • Communications representation: to support clear, coordinated organisational communication on FGA / sustainability matters and support increased visibility throughout the organisation.		Ideas identified through other NHS Wales organisations • Using the SMB or other means to undertake deep dives to verify if the SDP and 5WoW are being implemented and embedded throughout the organisation.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		

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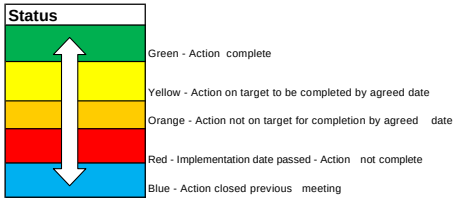

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Wellbeing of Future Generations Act					Advisory Report			Date Received at Audit Committee: 19 July 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	
Re	The Trust should ensure it has a coordinated FGA communications plan and that all communications avoid the use of, or clearly explain, any jargon and terminology used.		Ideas identified through other NHS Wales organisations • Incorporating sustainability into job descriptions. • Engaging all staff in developing action plans, whether it be those that support implementation of the strategies or those arising from any self-assessment undertaken. • Embedding the FGA and sustainability into staff awards. • E-guides covering different themes (e.g., biodiversity, travel, procurement) to get staff thinking and empower them to make individual choices. • Online workshops encouraging teams to look at their impact (e.g., around biodiversity, travel, emissions, etc) and how they can improve in these areas to support positive actions. • FGA / sustainability webpage to increase visibility internally and externally. • Running divisional / directorate workshops or undertaking staff surveys to ascertain awareness levels and	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendatio n 7	The Trust should work with other NHS Wales organisations to identify and developing mechanisms to effectively capture and report on contributions to the wellbeing goals.		Ideas identified through other NHS Wales organisations • Maintaining / publishing a directory of projects identify which wellbeing goals, ways of working and organisational wellbeing objectives the projects contribute to.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental	N/A		
Recommendation 8	As the Trust reviews its policies and procedures during the normal course of business (i.e., when each document is next due for review), it should ensure the FGA (including the SDP and 5 ways of working) is considered during the review process. The updated document should clearly link to the wellbeing objectives and 5WoW.			Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation 9	The Trust should seek further opportunities to pursue joined up working within NHS Wales and throughout the wider Welsh public sector. Examples include: • Making links with the Public Health Wales Health & Sustainability Hub; • Joining the Sustainable Development Coordinators Cymru Plus network (SDCC+); and • Making links, and developing relationships with, the Public Service Boards in the areas the Trust works.		Conclusion: The Trust is generally in a positive position regarding the success factors. We have identified recommendations for further enhancement, the key areas being around understanding the organisation's sustainability culture, developing mechanisms to capture and report on contributions to the wellbeing goals and SDP, and seeking further opportunities for joined up working across Wales.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		
Recommendation 10	The Trust should consider how it can efficiently and effectively incorporate FGA considerations / gap analysis into its projects and bidding processes for expenditure (capital and non-capital) going forward, including where the spend does not meet the criteria for more formal project management processes.		Conclusion: A comprehensive FGA gap analysis has been undertaken on the development of the new Velindre Cancer Centre. Areas for improvement are being identified and the analysis is being revisited at key stages of the project to demonstrate improvements made and identify further action required.	Carl James, Director of Strategic Transformation, Planning & Digital	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development and Rhiannon Freshney, Environmental Development Officer	N/A		

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Velindre UNHS Trust

Follow Up: Previous Recommendations Final Internal Audit Report					Assurance Rating: Reasonable Assurance			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Requested Extension Date
New Matter Arasing	**Trust Audit Action Tracker (Design)** 1.1 a. The Trust should develop a documented process for the governance of its Audit Action Tracker, considering the findings of this report and covering: i. roles and responsibilities of: • the Board and Audit Committee; • Internal and External Audit (and other reporting bodies where appropriate); • Executive Leads and responsible individuals identified in reports, including the requirement for oversight, accountability and scrutiny by the Executive Leads; and • those charged with maintaining the Tracker. ii. the process for providing management responses to audit recommendations, including expectations on the quality of the responses; iii. mechanisms to ensure all recommendations are included within the Tracker, including recommendations raised in follow up reports; iv. the process for managing updates to recommendations on the Tracker; v. expectations on the quality of updates and justifications for extensions to deadlines or recommendation closure; vi. clarity on the expectations of Internal and External Audit (and other reporting bodies, for example Healthcare Inspectorate Wales) on what is required to close a recommendation; vii. regular review of the Tracker to identify themes, e.g., lack of progress in implementing recommendations or common issues occurring which may benefit from a Trust-wide solution or an alternative approach to ensure effective resolution; and viii. Audit Committee reporting requirements – this should consider the appropriate level of information required by the Audit Committee to provide an overview of implementation status and to hold the Trust to account for timely implementation of recommendations.	High	1.1 a. Recommendation accepted Meeting held with Internal Audit on 5th May to discuss to the governance process for the Audit Action Tracker and how this process can be improved. Action: A paper to be presented to Division SLT/SMT and EMB identifying learning and recommending improvementsto the Audit Action Tracker process including a documented process covering items set out in 1.1(a) and using other learning from examples provided from other NHS Walesorganisations	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	Jun-22	Action Closed	A Governance of Internal and External Audit Reports, Recommendations and Management Action Tracking Paper was endorsed for Committee approval in EMB 01 July 2022 and was taken to the Audit Committee 19 July 2022. The paper identified learning and recommended improvements to the Audit Action Tracker process and included documented processes.	n/a	n/a
New Matter Arasing	1.1 b. The Audit Committee should approve the Audit Action Tracker Governance process.	High	b. Recommendation accepted Action: Paper to be presented to EMB and documented process for Audit Action Tracker to be approved by Audit Committee.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	19th July 2022 Audit Committee	Action Closed	The Audit Committee noted, discussed, reviewed and approved all recommendations in the Governance of Internal and External Audit Reports, Recommendations and Management Action Tracking Paper that was brought to the Audit Committee 19 July 2022	n/a	n/a

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Follow Up: Previous Recommendations Final Internal Audit Report					Assurance Rating: Reasonable Assurance			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Requested Extension Date
New Matter Arasing	1.1 c. The approved process should be communicated to all relevant staff, for example, through inclusion of a link when Internal Audit (or other reports) are sent out.	High	c. Recommendation accepted Action: The approved process will be communicated to all relevant staff	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	By end July 2022	Action Closed	The Audit Action Tracker governance process was approved by the Audit Committee on 19 July 2022. The process document will be sent out by 31/8/22 to all staff that were asked to proivde audit action updates un August. It will also be included as an attachment to the Action Tracker update requet e-mails that will be sent to relevant staff each month. A link to the procedure will also be embedded in the Audit Trackeritself.	DoF led on improvements to format and process for action tracking with new Procedure completed	n/a
New Matter Arasing	1.2 The Trust should undertake a thorough review of the current Tracker to ensure: • all recommendations are included as appropriate; • action updates and justifications to deadline extensions are clear and appropriate; and • all relevant information is included in the Tracker where parts of recommendations with multi-part responses have been closed.	High	1.2 Recommendation accepted Action: The DoF Business Support Officer has already undertaken an initial review of the action tracker and sought from action owners clarity on specific actions and target dates as well as formal request to close actions requiring a summary confirming the key actions taken to justify closure. The DoF will ask a senior member of the Finance Team to undertake a further review of the current Tracker specifically in relation to the 3 points identified.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	19th July 2022 Audit Committee	Action Closed	The Audit Action Tracker is now circulated monthly for updates to Responsible Manager and Executive Leads, with their BSOs Ccd in an attempt to obtain clarity on specific actions and target dates. A paper will be taken monthly to EMB to follow up on any outstanding recommendations with Executive Leads. All past closed action have been agreed by the Audit Committee to remain on the tracker and be marked as Blue. The DoF has reviewed the tracker to ensure: • all recommenations are included; • the governance procedure sets out requirement for justifications to deadline extensions and action updates are clear; • all relevant info is included in tracker where parts of recommendations with multi-part responses have been closed	n/a	n/a
New Matter Arasing	1.3 We concur with the decision to keep all action updates (not just the previous two) to create a more robust audit trail and allow for effective trend monitoring. Going forward, the Trust should also ensure the Tracker spreadsheet includes closed recommendations / actions rather than deleting them (filters or separate worksheets could be used to achieve this effectively).	High	Recommendation accepted Action: As the report states the Trust has already decided it would be more helpful to keep all action updates (not just the previous two) to create a more robust audit trail, assist the action lead in the quality & consistency of their action updates and enable effective trend monitoring. Action: The Trust has already	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	Already Actioned Already Actioned	Action Closed	n/a	n/a	n/a

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Priority	
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Medium	< 1 month *
High	Immediate *

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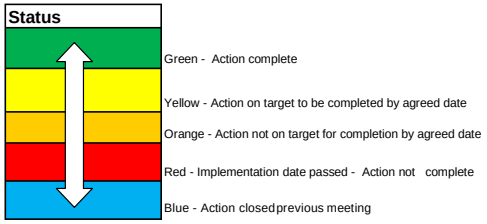
Follow Up: Previous Recommendations Final Internal Audit Report					Assurance Rating: Reasonable Assurance			Date Received at Audit Committee: 19 July 2022		
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022	Update September 2022	Requested Extension Date
Previous Matter Arising	2.1 The VCC WLWG and WLDG should ensure formal deadlines and actions are set to support compliance with the Welsh Language Standards, both in the meeting action logs and the RAG-rated compliance document.	Medium	2.1 Recommendation accepted The Action plan for VCC WLWG is being developed along with the introduction of new meetings and attendances. Deadlines for compliance against WL actions are set by the WL Standards document itself and the RAG rating demonstrates these timescales. Internal timescales will be set by the WLWG once the action plan has been finalised. Action: Action plan including deadlines to be agreed by VCC WLWG and WLDG.	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jul-22	Action Closed	Welsh language Action plan developed and agreed. New meeting shedule agreed.	n/a	n/a
Previous Matter Arising	**Velindre Cancer Centre Working Group (Operation)** 2.2 The ToR for the WLWG and WLDG should be updated and approved, including: • ensuring reference to appropriate group names throughout the ToR; • clearly defining roles and responsibilities of Group members; and • completing the quorum section (or deleting if not considered necessary).	Medium	2.2 Recommendation accepted Action: The TOR for the VCC WLWG and WLDG will be updated in line with recommendations	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jun-22	Action Closed	Action Ccmplete. The TOR for the VCC WLWG and WLDG have been be updated in line with recommendations.	n/a	n/a
Previous Matter Arising	2.3 The Trust should ensure the WLWG and WLDG meetings now take place at an appropriate frequency and attendance is monitored, with action taken to address issues with meeting frequency or non-attendance.	Medium	2.3 Recommendation accepted WLDG meetings have been formally agreed and a timeline for this year set. VCC WLWG meetings as stated above will now be held every month with the next meeting on the 30th of May. Action: WLDG and VCC WLWG to agree attendance monitoring process	Sarah Morley, Director of Workforce and OD	Jo Williams, Planning & Service Development Manager / Welsh Language Manager	Jun-22	Action Closed	Action complete. WLDG and VCC WLWG have agreed the attendance monitoring process.	n/a	n/a
Previous Matter Arising	Medical Workforce Planning – Action Plans (Design) 3.1 We concur with the approach taken by the Trust to incorporate workforce planning into the Velindre Futures programme. To provide assurance to the Audit Committee that medical workforce planning is in hand going forward, the CSQR Programme's Senior Responsible Officer should provide the Audit Committee an update report on work undertaken around medical workforce planning, for example, annually. This should be included on the Audit Committee Cycle of Business.	Low	3.1 Recommendation accepted Action: The CSQR Programme / medical workforce planning update report will be added to the Audit Committee Cycle of Business to be presented annually.	Sarah Morley, Director of Workforce and OD	Sarah Morley, Director of Workforce / Lauren Fear, Director of Corporate Governance / Senior Responsible Officer	Jun-22	Action Closed		Update October 2022: Complete Thr CSQR Programme / medical workforce planning update report has been added to the Audit Committee Cycle of Business.	Update October 2022: Complete Thr CSQR Programme / medical workforce planning update report has been added to the Audit Committee Cycle of Business.

Audit Action Plan



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

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Velindre UNHS Trust

nVCC Development: MIM Procurement Final Internal Audit Report					Assurance Rating: Substantial Assurance			Date Received at Audit Committee: 19 July 2022
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update August 2022
Detailed Audit Find	Procurement Strategy: Assurance that a Procurement Strategy had been adequately defined and appropriately applied.		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A
Detailed Audit Fin	Governance Structure: Assurance that an appropriate governance structure was in place in respect of the PQQ process and compliance was demonstrated against the same.		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A
Detailed Audit Fin	PQQ Evaluation Process: Assurance that a defined evaluation process was in place for PQQ's in preparation for key stakeholder approval (Trust and Welsh Government).		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A
Detailed Audit Fi	Document Management: Assurance that adequate document management has been retained to demonstrate the fair and equitable treatment of all bidders		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A
Detailed Audit Fi	Declarations of Interest: Assurance that appropriate guidance and procedures exist for the declarations of interest and compliance was demonstrated in respect of the same.		N/A Follow up previous nVCC MIM Governance 2021/22 Audit. Review of documentation, process and meetings to confirm actions are complete	David Powell, Project Director	Mark Ash, Assistant Project Director (Finance & Commercials)	N/A		N/A

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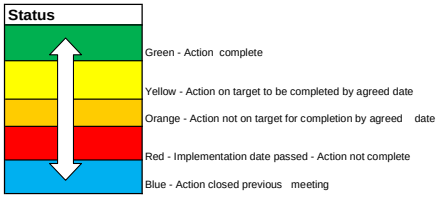

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Velindre UNHS Trust

External Audit Report - Audit of Accounts Addendum Management Letter					Assurance Rating: N/A			Date Received at Audit Committee: 19 July 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter Arising 1	Exhibit 1: Recommendations from 2021-22 audit of accounts **NWSSP IT assets with a gross book value of £570,000 that were disposed of in year remained in the Trust's Financial Statements in error .** Procedures for recording and approving the disposal of IT assets should be reviewed to ensure that all disposed assets are removed from the FAR on a timely basis, and prior to the production of the Trust's Financial Statements.	High	It is agreed that all assets should be disposed in a timely manner in line with the Trust Financial Control Procedure (FCP), "management of non-current / fixed assets and maintenance of asset register". This procedure will be reviewed in line with the recommendation and amended as appropriate. We will then ensure all staff across the Trust are familiar with the procedure and any amendments resulting from the review. NWSSP will in addition provide awareness sessions to all staff with responsibility for capital asset verification during 2022/23 to ensure they are fully aware of their obligations with regard to the disposal and reporting of fixed assets.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting & Linsay Payne, NWSSP Deputy Director of Finance & Corporate Services	31/12/2022	Action Closed	n/a	n/a		n/a	n/a
Matter Arising 2	**Our analysis of the FAR has identified that a significant percentage of some classes of asset have been fully depreciated but are still in use.** A review of the asset lives should be undertaken and consideration given as to whether there is sufficient evidence to depart from the suggested asset lives in the Manual for Accounts.	Medium	A review will be undertaken to see whether there is significant evidence to warrant departing from the manual of accounts.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting	31/08/2022	Action Closed	n/a	n/a		n/a	n/a

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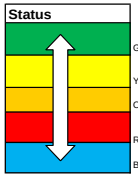
External Audit Report - Audit of Accounts Addendum Management Letter					Assurance Rating: N/A			Date Received at Audit Committee: 19 July 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter Arising 3	**There are weaknesses in the process for producing the TFR6 and we anticipate this will may impact on the LMS2 return for the Whole of Government Accounts.** The process of identifying the NHS Matrix agreed transactions in the ledger needs strengthening so that the production of the TFR6 can be produced more efficiently and reduce the risk of any balancing figures being needed. This should include once again reminding colleagues to ensure that transactions are coded to the appropriate codes.	Medium	We will continue to build on the work done last year to improve coding of transactions in the financial ledger. This will include reminding colleagues to ensure that the transactions are coded to the appropriate codes.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2023	Complete	Work continuing to improve process. Still on track to have strengthened process in place by deadline.	Work continuing to improve process. Still on track to have strengthened process in place by deadline.	Extensive work has been undertaken this year to ensure that the TFR6 can be mapped from the relevant notes in the accounts as far as possible. This will reduce the time taken to prepare the return, improve the accuracy of it, and allow more time to review it upon completion. Divisional finance colleagues have also been reminded of the importance of the coding of transactions and on a monthly basis are tasked with reviewing and amending the coding. Request made to CLOSE ACTION.	n/a	n/a
Matter Arising 4	**The Accounts Receivable Control account reconciliation has had an unreconciled difference of £141,000 since October 2021.** This reporting issue should be investigated to see if this issue can be resolved to remove this reconciling item from future reconciliations.	Low	This reporting issue has been subject to ongoing investigation since it occurred in October, and discussions will continue to identify both the cause and the action required to correct the AR reconciliation going forward.	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2023	Action Closed	n/a	n/a		n/a	n/a
Audit Year 2020-21	Exhibit 2: progress against previous years' recommendations Losses relating to a Structured Settlements have not been correctly recorded in the Trust's accounts Note 26.3 within the Trust's 2021-22 Financial Statements should include losses relating to Structured Settlement cases and discussions should be held with Welsh Government for the prior year figures to be restated.	High	Addressed in the 2021-22 Financial Statements Recommendation implemented	Matthew Bunce, Executive Director of Finance	n/a	2021/22 Accounts submission	Action Closed	n/a	n/a		n/a	n/a
Audit Year 2020-21	Coding of transactions for the production of the FR6 return and WGA (LMS2) return We recommend that those officers posting transactions are reminded of the need to use the appropriate coding	Low	Not fully addressed Recommendation included in the 2021-22 recommendations above. See Matter arising 3	Matthew Bunce, Executive Director of Finance	Claire Bowden, Head of Financial Operations	31/03/2022	Action Closed	n/a	n/a		n/a	n/a

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

nVCC: Enabling Works Final Internal Audit Report					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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matters Arising 1	**Projects Board Oversight & endorsement of the FBC (Operation)** 1.1 Future Assurance Project Boards should receive routine assurance on the progress of business case development, against agreed targets, and detail of the component cases and full FBC for appropriate scrutiny / endorsement.	Medium	Agreed. The Project will ensure that routine progress reports will be provided to the Project Board(s) to provide assurance on the businesscase development. The nVCC Project will be completing the nVCC FBC by Winter 2023 and so from October 2022, will provide a progress report to the monthly nVCC Project Board.	David Powell, Project Director at applicable projects	David Powell, Project Director at applicable projects	From October 2022 to February 2023	Overdue	Email from Internal Audit - Currently progressing the 2022/23 Enabling Works audit, which includes a follow up review of the recommendations made last year. Aiming to have a draft report published soon.				
Matters Arising 1	1.2 Future Assurance Project Boards should be appropriately involved in the endorsement of business cases, in accordance with agreed delegations frameworks / project plans.	Medium	Agreed. The Project Team and Business Case Lead always endeavours to involve the Project Board in endorsing the business case where timings allow. The key priority is to ensure the achievement of Trust Board approval dates. Project Plans always include a date for Project Board to endorse the business case.	David Powell, Project Director at applicable projects	David Powell, Project Director at applicable projects	At future projects	On Target	Email from Internal Audit - Currently progressing the 2022/23 Enabling Works audit, which includes a follow up review of the recommendations made last year. Aiming to have a draft report published soon.				
Matters Arising 2	**Gateway Review Recommendations (Operation)** 2.1 For completion, the Project Board should receive an update on the status of the Gateway 3 recommendations.	Low	Agreed. The EW Project will provide an update report at the EW Project Board in September 2022, confirming that all actions have been completed.	David Powell, Project Director at applicable projects	Mark Ash, Assistant Project Director	September 2022	Overdue	Email from Internal Audit - Currently progressing the 2022/23 Enabling Works audit, which includes a follow up review of the recommendations made last year. Aiming to have a draft report published soon.				

Audit Action Plan

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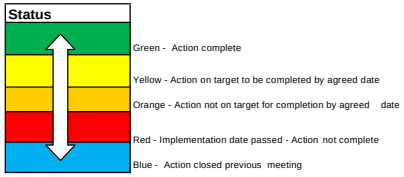
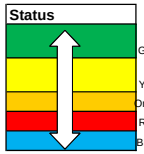


Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

nVCC: Enabling Works Final Internal Audit Report					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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matters Arising 3	**Project Initiation Document (Operation)** 3.1 The PID should be updated for the delivery of the construction phase.	Low	Agreed. The Project will update the PID for the delivery of the construction phase. This will be presented to the EW Project Board in October 2022.	David Powell, Project Director at applicable projects	Mark Young & Dawn Cudlip, Senior Project Manager	October 2022	Overdue	Email from Internal Audit - Currently progressing the 2022/23 Enabling Works audit, which includes a follow up review of the recommendations made last year. Aiming to have a draft report published soon.				
Matters Arising 4	**Risk Register (Operation)** 4.1 As part of the forthcoming scheduled review of the risk register (for the current juncture of the project), it should be enhanced to reflect the risks to the Trust in delivering the Enabling Works, if the MIM procurement is not successfully concluded.	Low	Agreed. The risk register will be reviewed to reflect the risk to the Trust. This will be presented o the EW Project Board in September 2022.	David Powell, Project Director at applicable projects	Mark Ash, Assistant Project Director	September 2022	Overdue	Email from Internal Audit - Currently progressing the 2022/23 Enabling Works audit, which includes a follow up review of the recommendations made last year. Aiming to have a draft report published soon.				
Matters Arising 5	**Single Tender Action reporting to Audit Committee (Operation)** 5.1 Single Tender Actions should be reported to Audit Committee in a timely manner.	Low	Agreed. The reporting of STAs is a corporate finance function but the Project will ensure that all relevant STAs are reported to the Audit Committee. This will be recorded on the Contracts Register. The Project will ensure that the Tree Clearance STA is reported to the next Audit Committee	David Powell, Project Director at applicable projects	Mark Ash, Assistant Project Director in conjunction with Matthew Bunce, Executive Director of Finance	Tree clearance STA: to the next Audit Committee Ongoing for future STAs	On Target	Email from Internal Audit - Currently progressing the 2022/23 Enabling Works audit, which includes a follow up review of the recommendations made last year. Aiming to have a draft report published soon.				

Audit Action Plan



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

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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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matter Arising 1	**Availability of the BC FCP (Operation)** 1.1 The BC FCP should be made available to all BHs. BHs should be made aware of its location.	Low	Recommendation accepted with the FCP already been made available on the Trust Intranet site. BHs will be informed of its location.	Matthew Bunce, Executive Director of Finance	Steve Coliandris, Head of Financial Planning & Reporting /David Osborne, Head of Business Partnering	31.10.2022	Action Closed	n/a	n/a	n/a	n/a	n/a
Matter Arising 2	**Budget Approval (Operation)** 2,1 The Trust Board should formally consider if it receives sufficient information to approve the annual budget and meet the requirement of the SO/SFIs.	Low	Prior to the development of the 2022-23 budget submission to Trust Board Management will review the SO/SFI requirements with regards to Budget Setting (Section 5.1), taking into account the Responsibilities and Delegation outlined in Section 2.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance	30.04.2023	On Target	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.		
Matter Arising 3	**Distribution / Acknowledgement of Budget Sub-Delegation Letters (Operation)** 3.1 Budget sub-delegation letters should be formally issued and acknowledged by all BHs, in line with the sub- delegation requirements of the budget delegation letters.	Medium	The BC FCP requires both Directors via chief Executive and Divisional Directors via the Chief Operating Officer to formally acknowledge the delegation with letters issued. There is flexibility for further sub-delegation with budget packs issued to BHs. Formal acknowledgement of sub-delegation to all BH's however will be incorporated as a requirement from next year.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering / Steve Coliandris, Head of Financial Planning & Reporting	30.04.2023	On Target	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.		
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.	On Target	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.		
Matter Arising 4	**Timelines of Budget Holder Reporting (Operation)** 4.1 The Trust should ensure BH information is issued in a timely manner. Inclusion of reporting and BH meeting timeframes in the month-end financial timetable may support this.	Medium	Management acknowledges some occurrences of delayed reporting due to temporary resource issues, however regular reports and meetings do take place. Timeframes to be included and adhered to within monthly timetable, with formal confirmation and records of completion.	Matthew Bunce, Executive Director of Finance	David Osborne, Head of Business Partnering	31.10.2022	Action Closed	n/a	n/a	n/a	n/a	n/a
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

Audit Action Plan

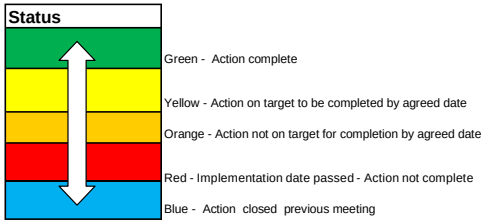
Velindre UNHS Trust

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

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

Finance & Service Sustainability: Budgetary Control & Savings Plans					Assurance Rating: Reasonable			Date Received at Audit Committee: 04 October 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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
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.	On Target	This is on target to be completed In line with the agreed revised implementation date	This is on target to be completed In line with the agreed revised implementation date	This is on target to be completed In line with the agreed revised implementation date		9 months

Audit Action Plan



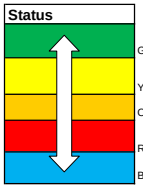
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Staff Wellbeing Final Advisory Review Report					Advisory Report			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	
Recommendation 1	We recommend that the Trust should fully explore and develop the means and measures by which the success or effectiveness of wellbeing initiatives will be determined. This should be undertaken as part of the planning and approval process for initiatives, prior to implementation. The measures identified should provide the Trust with data that can be used to determine intervention effectiveness as well as intervention usage.		n/a	n/a	n/a	n/a		n/a
Recommendation 2	We identified several points that the Trust may wish to consider further to support improvements in staff wellbeing: • wellbeing interventions implemented in other NHS Wales organisations that may not yet have been considered by the Trust – set out in paragraph 2.31; • the inclusion of additional factors in identifying the level of wellbeing within the Trust, e.g., presenteeism and leaveism and their impact on wellbeing; • consideration of useful wellbeing resources used by other NHS Wales organisations, e.g., What Works Wellbeing and NHS England Health and Wellbeing Programmes; and • wider consideration of preventative actions, such as the recommendations set out in the Kings Fund report, The courage of compassion (recommendations summarised in Appendix Four of this report).		n/a	n/a	n/a	n/a		n/a

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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	Complete	Education and Development team will attached the competency as an essential requirement for all supervisors and managers in ESR. The Workforce Development Manager will work with the Workforce Information Team to include this as part of the Performance Dashboard going forward	Education and Development team will attached the competency as an essential requirement for all supervisors and managers in ESR. The Workforce Development Manager will work with the Workforce Information Team to include this as part of the Performance Dashboard going forward	**Complete.** Managing Attendance at Work Training is recorded in ESR and each manager can view their team members' compliance through the ESR Dashboard. This will enable them to monitor compliance.	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.	
	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	Overdue	The Workforce Development Manager will work with the trainers and review current feedback / evaluation.	The Workforce Development Manager will work with the trainers and review current feedback / evaluation.	A standardised evaluation form will be introduced for all in-house management courses in April 2023	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 will allow the work to be completed as required.	4 months
	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	Complete	People and Relationships Advisors run regular MAAW training. Case studies and discussions of relevant and current issues are included in the training and managers are encouraged to contact them should they need to discuss individual cases		**Complete.** Case studies completed into the training and support provided to managers.		
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	Complete	**Action now complete**. SLT and SMT have been reminded and have cascaded the information to their teams. People and Relationships Advisors hold regular operational meetings with managers to address specific feedback and discuss all elements of sickness absence, particularly correct recording on ESR. Managers are asked not to use 'other' or 'unknown' as reasons for absence and to follow the guidance on how to correctly record the episodes of covid.	n/a	n/a	n/a	n/a

Audit Action Plan

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

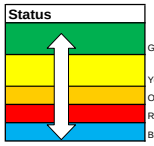
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* 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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
	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	Complete		Guidance requested as to the ability to separate this data out of ESR to determine accuracy.	**Complete.** Reviews have been undertaken in areas with identified issues from WOD perspective and ratified where errors have been identified. This will continue through the normal auditing process. Guidance now been provided to Senior Managers and is being cascaded in collaboration with Workforce.		
Matters	**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.		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 31st December 2022		People and Relationships Advisors hold monthly meetings with managers where the compliance with MAAW is incuded on the agenda. Complete SLT and SMT have been issued key messages for accurate storage and recording of data for cascading to managers. Complete Checklist of good practice available in MAWW templates on the intranet and this has been added to the training. Complete The rolling out of the staff personal files is complete in WBS and was paused in VCC and Corporate due to IT issues and lack of capacity due to the roll out of WPAS and DHCR. Radiotherapy are the first department to be rolled out in VCC which will be completed in the next couple of weeks - prep work is in progress. Once this department is completed the plan will be to move to the next department (hopefully Nursing although needs a lot of prep work to roll this one out)		VCC e-filing programme underway significant delays due to service managers availability to complete the required transfer. WOD and Digital services have completed the initial plan and requirement. Based on the additional Workforce pressure from the DHCR roll out we are asking for an extension of 4 months. Operational time has been constrained as a result of DHCR and this action has had to be deprioritised.. Firm timelines are now being agreed with each department.	31 August 2023 31 August 2023	9 Months 8 Months
	3.2 Pursue the rollout of centralised personnel folders for VCC, in line with the solution implemented within WBS.		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			The issue with the roll out of the files was paused during covid and to be able to get the ball rolling again it has been dependent on capacity but also Digital Over the last few months Digital have not had the capacity to support the roll out with WPAS and all their other priorities but we are now in a position to move and had prepped ready to start with Radiotherapy. This will require time from the department managers also so if they can't do this in Nursing currently, will speak to Therapies and roll out the smaller departments first.	This will require time from the department managers also so will need to roll out at pace managers, Digital and People and OD can co-ordinate. see info above in 3.1		
	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.		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		Complete on Audit Report Taken to January 2023 Audit Committee.	n/a	n/a	n/a	n/a

Audit Action Plan



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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

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 January 2023	Update Febuary 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matters Arising 1	**Meeting Structure** 1.1 As part of the review of quality and safety governance and reporting mechanisms, the Trust should: 1.1a. review the flow of patient and donor experience reporting 'from floor to Board' to ensure it is clear and efficient, avoiding unnecessary duplication;	Medium	a. A patient / Donor experience feedback procedure to be developed and published on intranet identifying reporting flow service level to Board.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Nigel Downes, Deputy Director Nursing, Quality & Patient Experience	31/03/2023	Overdue	Patient/Donor experience feedback procedure under development. The procedure will be reviewed by the Integrated Quality prior to uploading to the Trust's Intranet site.	No further update.	The BI team is working on dashboard reporting of data collated from CIVICA, including all patient and donor feedback. BI is currently working with CIVICA to a 2 week deadline. This report will need approval prior to publication. Overdue due to change in Personnel and absence.	30-May-23	2 Months
	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	Complete	The WBS Regulatory Assurance and Governance Group is being reviewed and re-shaped to become the WBS Quality Hub. The new ToR will incorporate Donor feedback surveys, Civica feedback and concerns/compliments allowing for triangulation with other quality markers. VCC - The Quality and Safety team has a plan to liaise with the directorates to identify all of the meetings that need to be included. Working with the chairs to update the terms of reference and ensure robust systems in place for the chairs to idenify the CIVICA/ patient feedback information including themes and trends - how to access it and how to demonstarte actions have been taken. A new postholder will join the Q&S team specifically for patient experinec at the end of March 2023. A meting is planned with the new Patient Enagement Manager to ensure shared objectives and to reduce duplication.	VCC - The Quality and Safety team are meeting with the directorate leads to ensure Civica is included as a key feature in each directorates meeting structures. The Q&S team are providing reports to ensure that feedback is widely shared and is regaulraly update using the 'knowing how we are doing' boards. the Q&S team are working with the meeting chairs to develop dashboards and identify the level of information and type of report required, developing individual questions which are department specific as requested and increasing use of the departement specific QR code. VCC now has a part time patient experince lead in place with responsibility and objectives set in relation to Civica - this post will become full time from April 1st 2023.	**Complete.** **VCC -** Communication made with all directorates to include CIVICA/ patient experience to their directorate management meetings TOR and standing agenda item. The Q+S team continue to work with meeting chairs to develop dashboards and identify the level of information and type of report required. This includes developing a monthly CIVICA patient feedback report to be sent to each directorate in readiness for their monthly meetings. From 1st April 2023 there will be a full time Patient Experience and Concerns Manager in post who will work closely with directorates to develop individual questionnaires applicable to each area. The Integrated Care lead has met with the Value Based Health Care project consultants to discuss the PROMS and PREMS work that has commenced and further work/meetings are planned with the PSC. **WBS -** Regulatory and Assurance Governance (RAGG) Review is being completed. Until the review is complete CIVICA Donor Satisfaction Survey results and concerns and compliments report are received, reviewed and reported within the monthly Donor Governance report at RAGG, Donor Clinical Governance Group and Collections Operational Service Group.		
	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, Deputy Director Nursing, Quality & Patient Experience	31/03/2023	Overdue	See update relating to 1.1a above.	No further update.	See update relating to 1.1a above.	30-May-23	2 Months

Audit Action Plan

Velindre UNHS Trust

Status

- Green - Action complete
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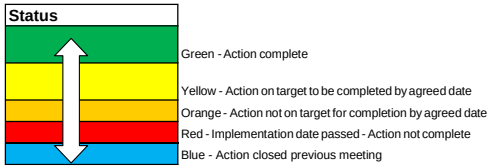
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

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 January 2023	Update Febuary 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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	Complete	The WBS Regulatory Assurance and Governance Group is being reviewed and re-shaped to become the WBS Quality Hub. The new ToR will incorporate Donor feedback surveys, Civica feedback and concerns/compliments allowing for triangulation with other quality markers. VCC - The Quality and Safety team are meeting with the directorate leads to identify what is included in their meeting structures to ensure Civica reports are a key feature also providing support to ensure that feedback is shared and is added to the 'knowing how we are doing' boards. Working with the meeting chairs to develop dashboards and identify the level of information and type of report required, developing individual questions which are department specific as requested and increasing use of the departement specific QR code.	VCC - The Quality and Safety team are meeting with the directorate leads to ensure Civica is included as a key feature in each directorates meeting structures. The Q&S team are providing reports to ensure that feedback is widely shared and is regaulraly update using the 'knowing how we are doing' boards. the Q&S team are working with the meeting chairs to develop dashboards and identify the level of information and type of report required, developing individual questions which are department specific as requested and increasing use of the departement specific QR code. VCC now has a part time patient experience lead in place with responsibility and objectives set in relation to Civica - this post will become full time from April 1st 2023.	**Complete.** **VCC -** Communication made with all directorates to include CIVICA/ patient experience to their directorate management meetings TOR and standing agenda item. The Q+S team continue to work with meeting chairs to develop dashboards and identify the level of information and type of report required. This includes developing a monthly CIVICA patient feedback report to be sent to each directorate in readiness for their monthly meetings. From 1st April 2023 there will be a full time Patient Experience and Concerns Manager in post who will work closely with directorates to develop individual questionnaires applicable to each area. The Integrated Care lead has met with the Value Based Health Care project consultants to discuss the PROMS and PREMS work that has commenced and further work/meetings are planned with the PSC. **WBS** - Regulatory and Assurance Governance (RAGG) Review is being completed. Until the review is complete CIVICA Donor Satisfaction Survey results and concerns and compliments report are received, reviewed and reported within the monthly Donor Governance report at RAGG, Donor Clinical Governance Group and Collections Operational Service Group.		
	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	Emma Powell, Head of Information	30/04/2023	On Target	Work is underway on the Specifications for the Quality and Safety Dashboard. This will include the specification for the reports required from CIVICA outcome measures.	Meeting with CIVICA is schedule for the 13th Feb to provide access to the data to intergrate with the Data Warehouse.	Meeting with CIVICA was held on the 13th Feb. Work in ongoing to get access to the data so that it can be integrate with the Data Warehouse. BI Dashboard yet to be delivered.		
	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	Complete	As 2.1a	As 2.1a	**Complete.** See update for 2.1a		
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, Deputy Director Nursing, Quality & Patient Experience	31/03/2023	Overdue	See update relating to 1.1a above.	No further update.	See update relating to 1.1a above.	30-May-23	2 Months

Audit Action Plan



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

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Velindre UNHS Trust

Decarbonisation					Advisory Report			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	
Matters Arising 1	Appropriate strategies should be developed to ensure that recruitment and retention issues experienced to date do not impact significantly on the achievement of the DAPs.	N/A	Agreed – Initial recruitment required to deliver plan complete Continuous review of additional skills/capabilities will be undertaken against the Decarbonisation Plan as it moves through phases	Carl James, Director of Strategic Transformation, Planning & Digital.	Carl James, Director of Strategic Transformation, Planning & Digital.	Annual review	Complete / N/A	
Matters Arising 2	DAPs should be fully costed to fully determine the total funding required.	N/A	Agreed Fully costed decarbonisation plan being developed	Carl James, Director of Strategic Transformation, Planning & Digital.	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development	March 2023	N/A	
Matters Arising 3	DAPs should be supported by funding strategies e.g. differentiating between local/ national funding, revenue or capital funding etc.	N/A	Agreed Trust will develop a funding strategy to deliver the requirements set out within the decarbonisation plan as part of Integrated Medium Term Plan 2023 -2026. Some funding requirements will be outside the immediate control of the Trust e.g. revenue funding from LHB commissioners and/or capital from the Welsh Government	Carl James, Director of Strategic Transformation, Planning & Digital.	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development	April 2023	N/A	
Matters Arising 4	NHS Wales Organisation's baselines should be adequately scrutinised and challenged, as errors and overreporting has been identified in a few examples to date.	N/A	Agreed Initial baseline submitted The Trust will work with the Welsh Government to improve the quality of data if any issues are identified	Carl James, Director of Strategic Transformation, Planning & Digital.	Environmental Development officer		Complete	

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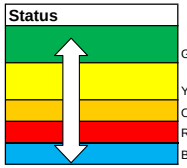

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Velindre UNHS Trust

Decarbonisation					Advisory Report			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	
Matters Arising 5	As a major contributor to the achievement of the targeted reductions appropriate engagement will be established with NWSSP Procurement Services (and formalised as appropriate).	N /	Agreed The Trust will support NWSSP in developing and agreeing targeted reductions required by Velindre University NHS Trust	Carl James, Director of Strategic Transformation, Planning & Digital.	Assistant Director of Estates, Environment & Capital Development	April 2023	N /	
Matters Arising 6	Proposed management/accountability structures should be fully implemented as intended within the DAPs.	N /	Agreed Accountability structures are currently in place. These will be strengthened following the development of the costed Decarbonisation Plan	Carl James, Director of Strategic Transformation, Planning & Digital.	Jason Hoskins, Assistant Director of Estates, Environment & Capital Development	June 2023	N /	
Matters Arising 7	Where decarbonisation falls within the existing environmental remit of committees/ meetings, it is important that an appropriate profile is set. Terms of Reference and agendas should be reviewed to ensure that sufficient focus is provided.	N/A	Agreed It will be strengthened within the Terms of Reference of the Executive Management Board; Strategic Development Committee and Quality, Safety and Performance Committee.	Carl James, Director of Strategic Transformation, Planning & Digital.	Carl James, Director of Strategic Transformation, Planning & Digital	March 2023	N/A	
Matters Arising 8	Potential collaboration and common utilisation of decarbonisation resource should be considered on an All-Wales basis, particularly in relation to consultancy advice and training resource.	N/A	Agreed The Trust will continue to seek opportunities to collaborate	Carl James, Director of Strategic Transformation, Planning & Digital.		This is an ongoing process and setting a single date is not appropriate	N/A	
Matters Arising 9	In accordance with the NHS Wales Decarbonisation Strategic Delivery Plan, HEIW/ collaborative training should be commissioned on an All-Wales basis to provide both common and tailored decarbonisation training.	N/A	Agreed The Trust will continue to seek opportunities to collaborate on training	Carl James, Director of Strategic Transformation, Planning & Digital.	Environmental Development Officer	This is an ongoing process and setting a single date is not appropriate	N/A	
Matters Arising 10	Given the scarcity of funding, it is important that bids for funding are appropriately considered prior to submission.	N/A	Agreed All schemes are considered via the Trusts existing governance arrangements	n/a	n/a	n/a	Complete	
Matters Arising 11	The same rigour and monitoring should be applied to internally commissioned/ funded initiatives to ensure the outcomes are adequately recorded/reported.	N/A	Agreed All schemes are considered via the Trusts existing governance arrangements	n/a	n/a	n/a	Complete	

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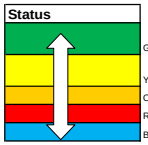

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High	Immediate *

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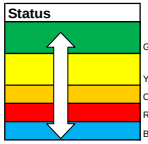
Velindre UNHS Trust

New Velindre Cancer Centre Development: Contract Management | **Assurance Rating: Limited** | **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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Matters Arising 1	**Contract Management Governance Framework (Design)** 1.1 The Trust should undertake a lessons-learned exercise in respect of contract management practices applied to date.	High	Agreed. The Project will contribute to the lessons learnt exercise undertaken by the Trust.	David Powell, Project Director	David Powell, Project Director with support of Mark Ash, Assistant Project Director (Commercials & Finance) and Matthew Bunce, Executive Director of Finance	23/04/2023	Complete			A detailed review paper including lessons learned and recommendations was discussed with IMs of the Audit Committee and Internal Audit on the 3.3.23. The key recommendation from this review paper and the Internal Audit report was the development and implementation of a Scheme of delegation for major capital projects. A delegation framework and specific scheme of delegation for the IRS project were presented to EMB Shape on 20.03.23 which was endorsed for review by the Audit Committee. This draft Framework Scheme of delegation and specific IRS Scheme of delegation is to be considered at the 23.04.23 Audit Committee for recommendation for Board approval in May '23.		
	1.2 The Trust should develop a fit-for-purpose governance framework for the effective and compliant management of adviser and construction contracts at the nVCC and EW projects (and future major capital projects within the Trust), to support compliance with SOs and SFIs. The Trust may wish to consider the following in developing the framework: • Whilst recognising on some occasions advisers need to be mobilised at short notice, to meet stringent timelines outside the Trust's control (e.g., responding to planning matters), proactive reporting to the relevant forum/s should take place wherever possible, to forewarn of the coming need to instruct a new contract / vary an existing contract. Early reporting may mean full costs will not yet be known, but this would enable the Board to be sighted at the earliest opportunity and grant preliminary approval if considered appropriate, within a range of potential costs. • Robust monitoring and reporting procedures are required to support such a framework. Triggers for escalation should be built into the framework when the running rate of costs is likely to exceed the approved contract sum. Expenditure against contingency sums should be monitored separately from expenditure against the	High	Agreed. The Trust has developed a contracts management framework to effectively manage the Enabling Works and nVCC contracts to effectively identify when contracts need to be varied or renewed. In addition, the Trust will ensure that Approvals for Authority to Spend on contracts will reflect accurate estimates or quotations, with an appropriate contingency sum. Once contract sums are agreed and the Approvals for Authority to Spend are checked, any further Approvals for Authority to Spend will be progressed through the Internal Governance as a matter of urgency.	David Powell, Project Director	Mark Ash, Assistant Project Director (Commercials & Finance)	23/04/2023	Complete			A Scheme of delegation for major capital projects has been developed which was presented to EMB Shape on 20.03.23 and endorsed for review by the Audit Committee at the 23.04.23 meeting for Board approval in May '23.		
	1.3 Where NEC contracts are applied, involving the use of compensation events to vary the contract, management of an appropriate contingency allowance (accommodated within the project budget) could be delegated to a suitable level (e.g., Chief Executive), allowing compensation events to be approved within this contingency.	High	Agreed. The Project will report through the internal governance process the latest CEs position and obtain Approvals for Authority to Spend.	David Powell, Project Director	Mark Ash, Assistant Project Director (Commercials & Finance)	Ongoing	On Target					

Audit Action Plan

Velindre UNHS Trust



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Medium	< 1 month *
High	Immediate *

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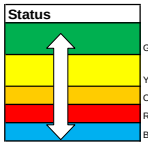
New Velindre Cancer Centre Development: Contract Management					Assurance Rating: Limited		Date Received at Audit Committee: 12 January 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
Previous MA 1.1	**Follow up of previously agreed management actions. Contract Documentation** The appointment process should be managed to ensure accuracy of the information reported to management i.e., contract value and timing of evaluation / acceptance.	Medium	Noted. The Project will improve the management of the contractor appointment process by implementing a quality assurance process that signs off contract documentation. Current Findings: Recognising fovcus on the MIM Priorities, this has not yet been progressed. Noting wider contract management issues identified at this year's audit, the appointment process should now be considered in conjunction with the new recommendation made. **Conclusion:** Superseded. See **MA1, Appendix A.**	David Powell, Project Director			Complete					
previous MA 1.2	Contract documentation should be signed in a timely manner and prior to the commencement of works.	Medium	Noted. The Project has improved processes to improve the timeliness of signing contract documentation to ensure all is signed within 30 days. **Current findings:** At the 10 contracts reviewed this year's audit, contracts were only in place prior to commencement of duties in two cases. Of the eight completed after commencement, none met the 30-day timeframe as per the management response (with a number remaining outstanding at the time of fieldwork, recognising Board approvals had been required). The difficulties in acheiving proactive contract execution, in some of the cases reviewed this year, are recognised. **Conclusion:** Superseeded. **See MA1, Appendix A.**	David Powell, Project Director			Complete					
Previous MA 3.1	**Contractor Performance and Key Performance Indicators** Reporting on contractor performance and Key Performance Indicators should be undertaken in line with expectation.	Medium	Noted. The Project will ensure that balanced scorecards for appropriate contractors will be reported to Project Board on a quarterly basis. **Current Findings:** Recognising focus on the MIM priorities, this has not yet been progressed. Noting wider contract management issues identified at this year's audit, the expectations for reporting should now be considered in conjunction with the new recommendation made. **Conclusion:** Superseded. See **MA1, Appendix A.**	David Powell, Project Director			Complete					

Audit Action Plan



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

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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 January 2023	Update February 2023	Update March / April 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	On Target	The PMF Project Group will continue to monitor and report progress against timelines and identified benefits/quality improvements the Project Plan but will include any resource and cost implications (nil Phase1) in Phases 2 and 3 going forward and lessons learned	PMF Project Group continuing to monitor progress which remains on track.	PMF Project Group continuing to monitor progress which remains on track. First complete set of EMB, QSP Cttee and Trust Board PMF Performance reports issued based on January data. Feedback received from EMB Run discussions 2nd March and PMF reports amended.		
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	On Target	PMF Training 'familiarisation workshops' (over 50) have already been delivered (Nov/Dec 22) to staff producing performance reports in the 'new style' by Peter Gorin and Anna-Marie Jones. During January a further series of Team training sessions on SPC charting is being delivered by Michelle Evans, supported by Peter Gorin.	SPC training delivered to staff.Training session to be offered to Independent Members or recorded session to be made available.	Training video recording (best session being identified) available for Independent Members		
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	On Target	A set of completed 'exemplar' KPI Supporting Data Templates, across VCC, WBS and Support Services have been completed and shared on the dedicated New Prototype PMF Teams Channel. Work continues supporting staff completing narratives (SMART) and analysis in the new style PMF performance reports.	Continuing dialog and ongoing support being given to staff via the dedicated PMF Teams channel. Excellent engagement across Trust with 99 operational leads participating in PMF performance report completion	First complete set of EMB, QSP Cttee and Trust Board PMF Performance reports issued based on January data. This iteration has improved completion and SMART 'er' actions and narratives		
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	On Target	Discussions with VCC, WBS and Support Services leads on more appropriate performance baselines for April 2023 will be concluded prior to the production of the first new financial year PMF reports. Explore best ways to highlight where forecast performance is unlikely to meet required targets.	Development of PMF KPIs and appropriate performance baselines on track for April 2023/24 reporting.	Development of PMF KPIs and appropriate performance baselines remains on track for April 2023/24 reporting.		

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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 January 2023	Update February 2023	Update March / April 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	On Target	The template designed will be completed, recording agreed and approved KPI changes, and cross referenced in the KPI Glossary of Definitions and Calculation Bases (see 4.2 and 5.3 below)	KPI Glossary of Terms completion for existing KPIs on track completion by end of February 2023	PMF Project Group 14/3/23 to Review VCC and WBS KPIs definitions and calculations		
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	On Target	The KPI Glossary of Definitions and Calculation Bases is partially populated but will be completed prior to April 2023.	KPI Glossary of Terms completion for existing KPIs on track completion by end of February 2023	PMF Project Group 14/3/23 to Review VCC and WBS KPIs definitions and calculations		
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	The Director of Strategic Transformation, Planning & Digital will work with VCC, WBS and Support Services Directors to ensure adequate evidence is retained in the Divisions to support the performance reported within the PMF (see 5.2 below)	A SOP will be developed to document the required evidence as per previous updates (see 5.1 and 5.2) Flowcharts for PMF production in VCC, WBS and EMB to QSP anf Trust Board have been prepared.	Performance Accountability Framework (PAF) Subgroup progressing a VUNHST PAF and Accountability Scheme of Delegation and will include responsibilities around evidence retention		
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	A SOP will be developed to document the required evidence retention processes within VCC, WBS and Support Services (see 5.1 above)	Monthly PMF Executive Directors Certification document developed, requiring positive assurance that they have reviewed and approve the performance data and supporting analysis as a true and fair view of the Trust's performance.	Performance Accountability Framework (PAF) Subgroup progressing a VUNHST PAF and Accountability Scheme of Delegation		
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	On Target	The KPI Glossary of Definitions and Calculation Bases will include an assessment of the quality and reliability of source data prior to April 2023.	KPI Glossary of Terms completion for existing KPIs on track completion by end of February 2023	PMF Project Group 14/3/23 to Review VCC and WBS KPIs definitions and calculations		

Audit Action Plan

Status	
	Green - Action complete
	Yellow - Action on target to be completed by agreed date
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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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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	Overdue	On target	No further update	5 new improvement goals iweaved into sections of IMTP aligned with safe care collaborative priorities. Being explicitly pulled out to add to Quality sections.	30-Apr-23	1 Month
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	Complete			**Complete.** The TAF has been developed and become a working document, updated and submitted to Boards with the relevant extract received by each Committee and in full by both Audit Committee and Strategic Development Committee in line with their agreed remits..		
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	Complete			**Complete.** Gaps in control and assurances are now reveiwed regularly and scrutunised at Board and Committees in line with process established outlined as per update R2..		
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	Complete			**Complete.** Following review with Independent Members who are part of Audit Committee a revised Risk Register template has been developed, which will now be reported to Board and Committees effective through May governance cycle..		

Audit Action Plan

Velindre UNHS Trust

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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	Complete			**Complete.** The revised Board / Committee cover report details committees where risk has been considered and any relevant discussion against specific risks. This will be operationalised via the May governance reporting cycle.		
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	Complete			**Complete.** Risk management is developing further through Team and Senior Leadership meetings and will be owned by respective Executive Leads at the Trust Board / Committees via May givernance cycle.		
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	Complete	Feedback on the engagement exercise was presented to Executive Management Board in December 2022. The output of this was the commissioning of further work part of which will be to continue work on the culture of the organisation. Multiple sources of feedback are being utilised to develop an approach which will be fed back to Executive Management Board in March 2023. Specific individual interventions are also used in instances where hotspots are identified of challenging behaviours in the Trust. This action is closed.	n/a	n/a	n/a	n/a
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	Complete	As Above (R4a)	n/a	n/a	n/a	n/a

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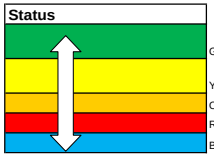
External Audit Report - Review of Quality Governance Arrangements - VUNHST					Assurance Rating: N/A			Date Received at Audit Committee: 12 January 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
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	Complete	Integrated Quality & Safety Group established	No further update	**Complete:** Integrated Quality & Safety Group established - initial meeting review undertaken and two groups stood down and work plan now embeeded in IQ&S Group operations (Datix project Board & Safety Alerts Group). Further ongoing work underway to develop robust meeting reporting structure - this will be ongong for the next 3months.		
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	Complete	There remained a data gap with VCC Q&S report - dates for reporting periods being mapped out	No further update	**Complete.** QSP Cycle of Business amended and reporting periods realigned.		

Audit Action Plan



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

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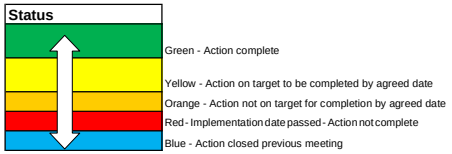
Velindre UNHS Trust

External Audit Report - Reviewing approach to Equality Impact Assessments					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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
R4	Reviewing public bodies' current approach for conducting EIAs While there are examples of good practice related to distinct stages of the EIA process, all public bodies have lessons to learn about their overall approach. Public bodies should review their overall approach to EIAs considering the findings of this report and the detailed guidance available from the EHRC and the Practice Hub. We recognise that developments in response to our other recommendations and the Welsh Government's review of the PSED Wales specific regulations may have implications for current guidance in due course.		A review of the current EIA process was commenced on 13.12.22 with the aim of making it simpler and focused towards action and improvement. This will include input from managers who need to conduct the assessments.	Sarah Morley, Executive Director of Organisational Development and Workforce	Claire Budgen	31.03.23	Cpmplete	Pilot of a new aproach for generating and implementing equality impact assessments is under development. Focus group looking at the Hybrdi Working framework is taking place on 9 February 2023 where a more focused approach wil lbe used. It is planned that the outputs of the focus group will be shared with all staff in order to achieve a rounded assessment. This is designed to be a learning excercise to test what is most effective when developing an impact assessment.	Toolkit and process in draft. Pilot session took place on 9.2.23 to test out process with managers. Other Health Boards' approaches have been accessed to help generate quality approach.	The action is now complete. The Review has been undertaken and as a result the Trust EQIA was updated. A toolkit shared with Healthy and Engaged Steering Group on 13.3.23 to obtain feedback prior to launch.		

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
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Velindre UNHS Trust

External Audit Report - The National Fraud Initiative in Wales 2020-21					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 January 2023	Update February 2023	Update March / April 2023	Requested Extension Date	Extension (Months)
R1	All participants in the NFI exercise should ensure that they maximise the benefits of their participation. They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.	N/A	The guidance will be reviewed by the Counter Fraud Manager and Head of Financial Operations, and this will be shared with the NWSSP Accounts Payable team who review the matches on the Trust's behalf.	Matthew Bunce, Executive Director of Finance	Gareth Lavington, Counter Fraud Manager and Claire Bowden, Head of Financial Operations	28/02/2023	Complete	Guidanace has been reviewed. This is a bi-annual exercise. It has not yet gone live in relation to the current data dump. When it does go live the Counter Fraud team review and investigate all high risk matches and a specimen sample of the lower risk matches. This exercise is in addition to all other Counter Fraud work carried out by the team and the time and resource provided will be satisfactory but balanced with other activity.	The NFI exercise has now gone live and the matches are and will continue to investigated as per previous exercises.	Action Completed as Per January Update		
R2	Where local auditors recommend improving the timeliness and rigour within which NFI matches are reviewed, NFI participants should take appropriate action.	N/A	Where these recommendations are made, appropriate actions will be taken.	Matthew Bunce, Executive Director of Finance	Gareth Lavington, Counter Fraud Manager and Claire Bowden, Head of Financial Operations	Ongoing	Complete	The Counter Fraud team will endeavour to meet all deadlines in relation to NFI. Indeed, in past exercises all deadlines and requirements have been met. It may not always be possible to respond accordingly as suggested due to the dynamic nature of Counter Fraud work as other areas may require prioritising.	As per update January 2023	Action completed as per January update. Updates for ongoing NFI work will be reported as normal via quarterly counter fraud progress reports.		
R3	Audit Committees, or equivalent, and officers leading the NFI should review the NFI self-appraisal checklist. This will ensure they are fully informed of their organisation's planning and progress in the 2022-23 NFI exercise.	N/A	The NFI self-appraisal checklist will be shared with the Audit Committee to ensure they are fully informed as described.	Matthew Bunce, Executive Director of Finance	Gareth Lavington, Counter Fraud Manager		Complete	Audit Wales Document re NFI self appraisal template document shared with members of the Audit Committee 17/01/2023.	As per update January 2023	Action Complted as per January update. Updates for ongoing NFI work will be reported as normal via quarterly counter fraud progress reports.		

Notification of the Risk of Legal Challenge to the Award of All Wales Contracts Pursuant to the Public Contract Regulations 2015 (PCR 2015)

1. Notification will apply to those procurements subject to the PCR 2015 which are let on an All Wales basis and for which Velindre University NHS Trust is named as the Contracting Authority.

2. Further to the commencement of the mandatory standstill period in accordance with Regulations 86 and 87 of the PCR 2015, NHS Wales Shared Services Partnership (NWSSP), Procurement Services will monitor and respond to all requests for clarification and further information received from the economic operators in respect of the proposed award decision.

3. During the mandatory standstill period, NWSSP Procurement Services will respond directly and, where necessary, consult with professional legal advisors and counsel to respond to challenges to the proposed award decision received from economic operators and/or their legal representatives. The objective of the communication process during the mandatory standstill period is to ensure that economic operators have all information available (as permitted and prescribed within PCR 2015) to understand fully the reasons for the proposed award decision. The mandatory standstill period may be extended to accommodate further rounds of clarification and questioning from economic operators and/or their legal representatives.

4. Prior to the conclusion of the mandatory standstill period, NWSSP Procurement Services will determine the viability of concluding the mandatory standstill period and proceeding to final contract award. The decision will be based on a consideration of the nature, subject matter and outcome of the communications with economic operators and/or their legal representatives during the mandatory standstill period.

5. In pursuance of this determination, NWSSP Procurement Services may, where considered necessary, seek and obtain a legal counsel risk assessment in relation to the probability of a legal notice being served by an economic operator in accordance with Regulation 94 of the PCR 2015 and, if a legal notice is subsequently served, the probability of a successful defence through the High Court. NWSSP Procurement Services will subsequently provide Velindre University NHS Trust with the outcome of the risk assessment received and, in this context, a proposal of whether to proceed with final contract award. NWSSP Procurement Services will request from Velindre University NHS Trust confirmation to proceed with this proposal prior to moving forward with the process. If confirmation to proceed is not agreed by Velindre University NHS Trust, NWSSP Procurement Services will pause the procurement until any issues are further discussed and addressed to the satisfaction of all parties.

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To:
NHS Audit Committee Chairs
NHS Directors of Finance
NHS Board Secretaries
The Chair of the NHS Technical Accounting Group
Steve Elliot – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Reference: AC350/3415A2023

Date issued: 1 March 2023

Dear colleague

NHS – Audit of Accounts 2022-23

We are about to commence our accounts audit work for all NHS bodies in Wales and I am conscious that the closure of the 2022-23 NHS financial statements will be challenging to both Audit Wales and the NHS.

In the attached letter, my Executive Director of Audit Services provides some important information on the introduction of a new auditing standard. The new standard fundamentally impacts how we will undertake the 2022-23 audit and has implications for you and your teams. The letter gives more detail on the standard itself and its impact on fees and the 2022-23 audit certification deadline.

I am acutely conscious that the message is a difficult one, with our fee rates increasing and deadlines moving later, at a time when colleagues everywhere in the public service are under great pressure. It is for that reason that I wanted to write to you directly, to explain the drivers behind the changes and to give my assurance that Audit Wales will be doing all it can, in the coming years, to continue to provide high quality audit, delivered efficiently, and that we have a plan to bring deadlines forward. I would like to thank you for your continued communication and engagement, which are so vital if we are to deliver those things.

In respect of the certification deadlines, the introduction of the revised Standard, and a radically different audit approach, has implications for audit timetables and it is inevitable that the new approach will require additional time to implement. I am also conscious that there will be additional challenges for finance teams preparing accounts this year, including the introduction of IFRS 16 – Accounting for Leases and accounting adjustments resulting from the quinquennial valuation of the NHS estate. It is important that finance teams have sufficient time to reflect these changes accurately in draft accounts submitted for audit to ensure a smooth audit process.

Given the circumstances set out above, I feel I have no option but to extend the audit certification deadline to 31 July 2023 to ensure I build in sufficient time to deliver an audit that meets my high standard in terms of audit quality.

That said, it is essential I recover this position in future years. In terms of my proposed certification deadlines in 2023-24 and 2024-25, I have signalled to my colleagues at Audit Wales the importance of recovering the position and a continual and collaborative dialogue with NHS colleagues is crucial.

To help us achieve the proposed certification deadlines set out in the attached letter, my Engagement Director and audit teams will continue to liaise closely with you and your colleagues. Notwithstanding the ongoing dialogue taking place at a local level, I have asked my Executive Director of Audit Services to arrange discussions with key stakeholder groups across the NHS. I hope that this is a helpful update and I wish you all the very best for the forthcoming audit of accounts.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

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[by-email]

Reference: 3415A2023

Date issued: 1 March 2023

To: NHS Directors of Finance
NHS Audit Committee Chairs
NHS Board Secretaries
The Chair of the NHS Technical Accounting Group
Steve Elliot – NHS Director of Finance Welsh Government
John Evans – Welsh Government
Jacqui Salmon – Welsh Government

Dear colleague

NHS – Audit of Accounts 2022-23

1 We are about to commence our accounts audit work for all NHS bodies. We are therefore taking the opportunity to write to you with some important information on the introduction of a revised auditing standard which fundamentally impacts on how we will undertake your 2022-23 audit.

2 Within this letter we consider:

- the impact of the revised standard;
- the resultant impact on audit fees; and
- the timetable for the Audit of Accounts 2022-23 and for future years.

The impact of ISA 315

3 Our audits of NHS accounts for the year ended 31 March 2023 will be carried out under a revised auditing standard (ISA 315 (UK) Identifying and Assessing the Risks of Material Misstatement (Revised July 2020)).

4 This revised standard is effective for audits of accounts for periods beginning on or after 15 December 2021 and applies to the audit of all private and public sector entities across the UK, regardless of their nature, size or complexity.

5 The revised standard will have significant and far-reaching impacts on how auditors undertake audit risk assessments and our overall audit approach.

6 In planning our audit, we will be required to undertake more detailed and extensive risk assessment procedures to identify risks of material misstatement. The subsequent design and performance of our audit approaches will be responsive to each assessed risk.

7 **Appendix 1** outlines the key changes and the potential impact on your organisation in terms of information requests from our audit teams.

8 The standard has been amended to drive better quality, more effective risk assessments, as well as to promote greater exercise of professional scepticism. It also requires us to obtain a much more robust understanding of an organisation's IT systems. Financial reporting frameworks and governance structures are becoming increasingly complex, while technology continues to play a more advanced role in the control environment of entities. These changes require risk identification and assessment to be enhanced and rigorous audit processes.

9 The previous standard did not address automated tools and techniques, which are increasingly being used by auditors to inform risk assessment. All audits of 2021-22 NHS accounts incorporated elements of our Analytics Assisted Audit. The revised standard introduces specific considerations relating to the auditors' use of automated tools and techniques.

Impact on audit fees

10 As a result of the changes outlined above, we expect 2022-23 audits to take longer to complete. We will also be required to use more experienced CCAB qualified staff on audits to deal with the higher level of judgement necessitated by the standard.

11 In our August 2022 Consultation on Fee Scales, we indicated that our initial assessment of the impact of this richer skill mix on fees was a potential average increase in fee scales for our financial audit work of between 12% and 18%. This is consistent with expectations in other UK public audit bodies and the private sector audit firms.

12 We have now started more detailed risk assessment under the new audit approach and will be able to provide you with an updated assessment of the audit fee once we have completed that initial risk planning. Our initial estimate is

that audit fees will increase by 10.2% for ISA 315, in addition to the 4.8% inflationary increase set out in our Audit Wales 2023-24 Fee Scheme . Your Engagement Director will discuss the proposed fee for your audit once that risk assessment has been completed.

Timetable for the Audit of Accounts 2022-23

13 The introduction of the revised Standard and a radically different audit approach has implications for audit timetables. We have worked closely with the other UK Public Audit Bodies to develop an audit methodology which, we believe, will add value to Audited Bodies whilst continuing to maintain the high-quality audit which we know you expect from us. However, it is inevitable that the new approach will require additional time to implement.

14 We are also conscious that there will be additional challenges for finance teams preparing accounts this year, including the introduction of IFRS 16 – Accounting for Leases and accounting adjustments resulting from the quinquennial valuation of the NHS estate. It is important that finance teams have sufficient time to reflect these changes accurately in draft accounts submitted for audit to ensure a smooth audit process.

15 We will be working closely with NHS finance teams over the next few weeks to agree the precise timings for submission of NHS draft accounts. There will also be logistical matters to consider, such as managing staff annual leave and potentially securing revised Audit Committee, Board and Annual General Meeting (AGM) dates. We are aware that Health Boards and Trusts must hold an AGM no later than 31 July each year as per Standing Orders.

16 From our discussions with Health Bodies, we are aware that a number of you are struggling to recruit experienced finance staff and that this may also impact audit timetables. We are facing similar challenges and know that this position is consistent with the National Audit Office (NAO), Audit Scotland and the Northern Ireland Audit Office. The NAO's recovery plan article is a useful reference in this context[1]. In addition, a more recent report by the National Audit

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[1] The NAO: getting government accounts back on track | ICAEW

[2]Timeliness of local auditor reporting on local government in England

Office (January 2023) highlights how the delays to local government audit opinions are impacting elsewhere in the public sector, including the NHS, and describes plans to get back on track with the timetable for published audit opinions[2].

17 For information, reporting deadlines in England are slightly more complicated, with providers and commissioners having different dates and different requirements around annual reports. The NAO have just published in their opinion for the Department of Health and Social Care Annual Report and Accounts 2021-22 (page 264) that 25% of providers in NHS England and 20% of commissioners failed to meet the Department of Health and Social Care audited accounts deadline in 2021-22.

18 As the auditors of Local Government Bodies in Wales, we have been experiencing similar delays to those seen in England in completing our audit of the 21-22 accounts. These delays result mainly from a technical issue regarding the valuation of Local Government infrastructure assets, which resulted in the Welsh Government deferring the audit certification deadline to 31 January 2023 and have impacted our ability to commence our 2022-23 audits in line with previous year timetables.

19 Taking all of this into account and having discussed with colleagues in Welsh Government responsible for preparing the NHS Consolidated accounts, we are therefore proposing an audit certification deadline of **31 July 2023** for NHS Bodies in Wales.

20 We recognise that this is later than many bodies would like but we believe it is important to set realistic timescales we can all work to. Over the next three years our plan would be to revert to a 15 June deadline as follows:

- Audit of Accounts 2022-23 – certification by 31 July 2023;
- Audit of Accounts 2023-24 – certification by 30 June 2024; and
- Audit of Accounts 2024-25 – certification by 15 June 2025.

21 You will note that by 2024-25, we are not intending to revert to the pre-covid 31 May deadline but will aim to certify accounts by 15 June. This will ensure that the time required for Health Boards and Trusts to circulate the requisite accounts and audit reports to the Audit Committee and the Board, does not compress the audit window to less than a month.

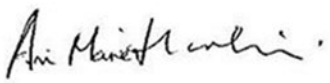
22 In respect of the Charitable Funds audit or the independent examination, we intend to complete these by the deadline set by the Charities Commission.

23 We value the constructive working relationship we have with your finance teams and will continue to work closely with you to bring forward the deadlines for future years.

24 We remain committed to working collaboratively with you to successfully navigate this challenge, building on our shared experiences. We will ensure we attend all the relevant NHS fora to discuss the content of this letter with you and will be arranging meetings with all NHS Directors of Finance and Audit Committee Chairs to provide you with an opportunity to meet with us all.

Thank you to you and your teams for working so well with us.

Yours sincerely



Ann-Marie Harkin
Executive Director Audit Services

Appendix 1 – the key changes to the standard and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (e.g. the network, databases); • IT processes (e.g. managing program changes, IT operations); and • the IT personnel involved in the IT processes. Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.

Key change	Potential impact on your organisation
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

Archwilio Cymru
Audit Wales

Velindre University NHS Trust

Outline Audit Plan 2023

Audit year: 2022-2023

Date issued: April 2023

This document is a draft version pending further discussions with the audited and inspected body. Information may not yet have been fully verified and should not be widely distributed.

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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. Audit Wales is not a legal entity and itself does not have any functions.

No responsibility is taken by the Auditor General, the staff of the Wales Audit Office or, where applicable, the appointed auditor in relation to any member, director, officer or other employee in their individual capacity, or to any third party.

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 the Wales Audit Office 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.

About Audit Wales

Our aims:

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Our ambitions:

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

Contents

Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend sharing a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends undertaking to address the audit risks identified and other key areas of audit focus during 2023.

Adrian Crompton
Auditor General for Wales

My audit responsibilities

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure, and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.

I am also required to certify a return to the Welsh Government which provides information about Velindre University NHS Trust (the Trust) to support preparation of the Whole of Government Accounts.

Performance audit work

I must satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Trust and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

Fees and audit team

In January 2023, I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates and also highlights the impact of the revised auditing standard ISA 315 on my financial audit approach. More details of the revised auditing standard and what it means for the audit I undertake is set out in **Appendix 1**.

I will provide an estimate of your fee in my Detailed Audit Plan that will be reported to the Trust's Audit Committee in July 2023, following completion of my detailed risk assessment.

Your engagement team:

Richard Harries	Engagement Director & Financial Audit Director	07789 397018 / 02920 320640
David Thomas	Performance Audit Director	07798 503064 / 02920 320604
Steve Wyndham	Financial Audit Manager	07891 179033 / 02920 320664
Darren Griffiths	Performance Audit Manager	02920 320591
David Burridge	Financial Audit Lead	07798 503066 / 02922 677839
Katrina Febry	Performance Audit Lead	07870 266701 / 029 20320616

We confirm that our audit team members are all independent of the Trust and your officers.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	March 2023	April 2023
2023 Detailed Audit Plan	March – April 2023	May 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	May – July 2023	July 2023
Performance audit work: • Structured Assessment, incorporating a deep dive into a specific thematic area which will be confirmed in the detailed plan in May 2023. • Local project work (to be confirmed in detailed plan in May 2023)	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study.	

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD[1] and our Chair acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2022.

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Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

[1] QAD is the Quality Assurance Department of Institute of Chartered Accountants in England and Wales.

Appendix 1 – the key changes to ISA315 and the potential impact on your organisation

Key change	Potential impact on your organisation
More detailed and extensive risk identification and assessment procedures	Your finance team and others in your organisation may receive a greater number of enquiries from our audit teams at the planning stage of the audit. Requests for information may include: • information on your organisation's business model and how it integrates the use of information technology (IT); • information about your organisation's risk assessment process and how your organisation monitors the system of internal control; • more detailed information on how transactions are initiated, recorded, processed, and reported. This may include access to supporting documentation such as policy and procedure manuals; and • more detailed discussions with your organisation to support the audit team's assessment of inherent risk.
Obtaining an enhanced understanding of your organisation's environment, particularly in relation to IT	Your organisation may receive more enquiries to assist the audit team in understanding the IT environment. This may include information on: • IT applications relevant to financial reporting; • the supporting IT infrastructure (eg the network, databases); • IT processes (eg managing program changes, IT operations); and • the IT personnel involved in the IT processes.

Key change	Potential impact on your organisation
	Audit teams may need to test the general IT controls and this may require obtaining more detailed audit evidence on the operation of IT controls within your organisation. On some audits, our audit teams may involve IT audit specialists to assist with their work. Our IT auditors may need to engage with members of your IT team who have not previously been involved in the audit process.
Enhanced requirements relating to exercising professional scepticism	Our audit teams may make additional inquiries if they identify information which appears to contradict what they have already learned in the audit.
Risk assessments are scalable depending on the nature and complexity of the audited body	The audit team's expectations regarding the formality of your organisation's policies, procedures, processes, and systems will depend on the complexity of your organisation.
Audit teams may make greater use of technology in the performance of their audit	Our audit teams may make use of automated tools and techniques such as data analytics when performing their audit. Our teams may request different information or information in a different format from previous audits so that they can perform their audit procedures.

Archwilio Cymru
Audit Wales

Archwilio Cymru
Audit Wales

Audit Committee Update – Velindre University NHS Trust

Date issued: April 2023

Document reference: ACU202304

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.

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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 are presenting an outline Audit Plan for our 2023 work programme to the committee on 25 April 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 Since the previous update, both the Auditor General and our Executive Director of Audit Services have recently written to NHS bodies, including the Trust, to set out the implications of the new auditing standard (ISA315) and the resulting slippage in the timing of when we are able to complete our 2022-23 accounts audit work. A revised audit deadline has therefore been set for 31 July 2023 and we are grateful to the Trust for rearranging the Audit Committee meeting to 26 July to accommodate this.

5 Whilst our planning work has commenced it is not complete and so as an interim measure, we have included an Outline Audit Plan within the papers for this Audit Committee meeting. We will present the full Audit Plan to the next Audit Committee meeting in July; however, it will be communicated to management (and if required Audit Committee members) during May.

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 and Executive Lead	Focus of the work	Current status and planned date for consideration
2022 Audit Plan		
Structured Assessment Director of Corporate Governance	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning • Use of resources (such as digital resources, estates, and other physical assets).	**Completed** To be considered April 2023 Audit Committee.
Workforce planning Executive Director of Organisational Development & Workforce	An assessment of workforce risks that NHS bodies are experiencing currently and are likely to experience in the future. The review will examine how local and national workforce planning activities are being taken forward to manage those risks and address short-, medium- and longer-term workforce needs.	**In progress** Anticipated to be considered at the July 2023 Audit Committee.
Local study To be confirmed	Topic to be confirmed. This budget is likely to be added to the 2023 budget.	**Not started** Timing dependent on work undertaken.

Area of work and Executive Lead	Focus of the work	Current status and planned date for consideration
2023 Audit Plan		
Structured Assessment Director of Corporate Governance	A review of the corporate arrangements in place at the Trust in relation to: • Governance and leadership. • Financial management. • Strategic planning	**In progress** Timing dependent on work undertaken.
Structured Assessment Deep Dive To be confirmed	Topic to be confirmed.	**Not started** Timing dependent on work undertaken.
Local study To be confirmed	Topic to be confirmed. Short piece of work either to review setting of Wellbeing and Future Generation Objectives or for a deeper dive module in an area covered by Structured Assessment. Likely to incorporate the 2023 remaining budget (local study).	**Not started** Timing dependent on work undertaken.

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**
'A missed opportunity' – Social Enterprises	November 2022
Time for change – Poverty in Wales	November 2022
Cyber Resilience Follow-up (report included in the January 2023 Private Audit Committee meeting papers)	October 2022
National Fraud Initiative 2020-21	October 2022

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
Audit Wales Annual Plan 2023-24	March 2023
Audit Wales Fee Scheme	January 2023
Audit Wales Interim Report 2022	November 2022
Audit Quality Report 2022: Building Trust in Audit	October 2022
Assure, Explain, Inspire: Our Strategy 2022-27	June 2022

9 There are no relevant Audit Wales consultations currently underway.

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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.

Annual Audit Report 2022 – Velindre University NHS Trust

Audit year: 2021-22

Date issued: March 2023

Document reference: 3369A2023

Purpose of this document

This document is a draft supplied in confidence solely for the purpose of verifying the accuracy and completeness of the information contained in it and to obtain views on the conclusions reached.

Handling prior to publication

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

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

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

Contents

Summary report

About this report

1 This report summarises the findings from my 2022 audit work at Velindre University NHS Trust (the Trust) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Trust, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services.

4 I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 As was the case in the previous two years, the delivery of my audit of accounts work has continued mostly remotely. The success in delivering it reflects a great collective effort by both my staff and the Trust officers.

6 I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. I have commented on how NHS Wales is tackling the backlog of patients waiting for planned care. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery.

7 This report is a summary of the issues presented in more detailed reports to the Trust this year (see **Appendix 1**). I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2022 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2022 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Executive Director of Finance have agreed the factual accuracy of this report. The Board received the report at the 30 March 2023 Board meeting and every member received a copy. We strongly encourage the Trust to arrange its wider publication. The report will be available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Trust's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit); however, I brought some issues to the attention of officers and the Audit Committee for improvement.

13 By following a Ministerial Direction to the Permanent Secretary of the Welsh Government, the Trust incurred expenditure on NHS Clinicians' pension tax liabilities, which I deem to be outside its powers to spend, so I issued a qualified opinion on the regularity of the financial transactions within the Trust's 2021-22 accounts.

14 The Trust met its financial duties in 2021-22; however, as my opinion was qualified regarding the NHS clinicians' pension tax issue, I issued a substantive report setting out the details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of Performance Audit work has led me to draw the following conclusions:

- Significant progress has been made to improve the Trust's quality governance arrangements.

- The Trust is generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance, and effective arrangements for managing its finances and other resources.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2022 Audit Plan set out the key risks for audit of the accounts for 2021-22 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2021-22 accounts

20 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. However, in common with most other NHS bodies in Wales we did qualify our regularity opinion in respect of clinicians' pensions tax liabilities, which occurred after the Trust followed a Ministerial Direction to the Permanent Secretary of the Welsh Government. My work did not identify any material weaknesses in internal controls (as relevant to my audit). However, I brought some issues to the attention of officers and the Audit Committee for improvement.

21 The Trust submitted its draft accounts within the required deadline. The accounts, and supported working papers, were of good quality, and officers of the Trust provided us with an appropriate level of support and engagement to enable us to complete the audit on a timely basis.

22 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues on 13 June 2022. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	There were two uncorrected misstatements above our trivial level but lower than our materiality level within the 2021-22 accounts: • In line with many other Welsh health bodies and in compliance with instructions from Welsh

Issue	Auditors' comments
	Government under Technical Update 7, the Trust had not applied the latest rate of indexation from the District Valuer in the calculation of land and building assets within the financial statements. This resulted in the asset carrying values (Net Book Value) being understated by £1,107,000 and the annual depreciation charged to expenditure being understated by £13,000. • Our sample testing identified a number of fully depreciated assets that had been disposed of but not removed from the Trust's Fixed Asset Register and therefore the accounts. As these assets have been fully depreciated, they had no Net Book Value and were therefore carried at nil value in the Statement of Financial Position, however the Gross Book Values and Accumulated Depreciation figures within Note 13 of the accounts were both overstated by £570,000.
Corrected misstatements	There were some misstatements in the accounts that were corrected by management. None of these were material.
Other significant issues	We reported one additional issue to the Audit Committee as a result of our audit. This related to the payment of bonus payments to several independent members contrary to a Welsh Government pay circular. The Trust has since taken action to recover these payments.

23 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position as at 31 March 2022 and the return was prepared in accordance with the Treasury's instructions.

24 My separate audit of the charitable funds financial statements is complete. The accounts were certified on 25 January 2023 prior to the Charity Commission deadline of 31 January 2023.

Regularity of financial transactions

25 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Trust does not have the powers to receive or incur.

26 The Trust incurred expenditure on NHS clinicians' pension tax liabilities, which I deem to be outside its powers to spend, so I issued a qualified opinion on the regularity of the financial transactions within the Trust's 2021-22 accounts. The Trust's accounts included £0.337million of expenditure and funding in respect of clinicians' pension tax liabilities. The amounts were included following a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government. The Ministerial Direction was required because this arrangement could be viewed by HMRC to constitute tax planning and potentially tax avoidance, hence making the expenditure irregular. Managing Welsh Public Money specifically states that "public sector organisations should not engage in…tax evasion, tax avoidance or tax planning". A Ministerial Direction does not make regular what would otherwise be irregular. Alongside my audit opinion, I placed a substantive report on the Trust's accounts to highlight the NHS clinicians' pension tax liabilities issue.

27 I have the power to place a substantive report on the Trust's accounts alongside my opinions where I want to highlight issues. Where the Trust fails one of its financial duties - to break-even over a three-year period and to have an approved three-year plan in place - or my opinion is qualified, I will issue a substantive report.

28 The Trust met its financial duties in 2021-22, reporting a small surplus of £41,000 at the end of the financial year. The Trust also achieved its statutory financial duty to achieve break-even over a three-year rolling period (2019-20 to 2021-22), reporting an overall three-year surplus of £103,000. My opinion, however, was qualified regarding the NHS clinicians' pension tax issue, so I issued a substantive report setting out the details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

29 I have a statutory requirement to satisfy myself that the Trust has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Trust over the last 12 months to help me discharge that responsibility. This work has involved:

- reviewing the effectiveness of the Trust's quality governance arrangements; and

- undertaking a structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

30 My conclusions based on this work are set out below.

Quality governance arrangements

31 My review examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. The review focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting.

32 My work found **that that significant progress has been made to improve the Trust's quality governance arrangements**. There are opportunities for improvement as set out in the paragraphs below.

33 The Trust has approved a new Quality and Safety Framework. It sets out the arrangements through which the Trust will meet its quality and safety responsibilities from floor to Board, clarifies roles and responsibilities, and sets out the ambition to ensure learning and improvement are embedded. The Trust has set out ambitious quality priorities and has appropriate arrangements to monitor delivery. However, quality priorities are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved.

34 Good progress has been made to improve the Trust's risk management arrangements. However, the Trust should ensure that risk reports provided for monitoring and scrutiny at all levels include the necessary detail to enable good scrutiny and challenge. The Board and its committees also need to ensure they scrutinise the Trust's progress in addressing gaps in controls and assurances of strategic risks. Furthermore, opportunities exist to improve the scrutiny of risks appearing in risk registers, both operationally and by the Board's committees.

35 The Trust's reporting of clinical audit has improved, although opportunities remain to demonstrate how learning is being embedded. The Trust has also made good progress in implementing the requirements of the Medical Examiner Service.

36 The Trust has a well-established Values and Behaviour Framework which encourages an open and learning culture. The Trust's compliance with statutory and mandatory training is good but has been impacted by the pandemic. The Trust demonstrates a strong commitment to learn from service user and staff experiences. There are good arrangements to collect service user feedback, which have been enhanced by an electronic system to collect real time feedback and a new patient engagement strategy for cancer services. There is a culture of staff feeling able to raise concerns; however, some staff are concerned that the Trust will not act in response to concerns.

37 The new Quality and Safety Framework has enabled the Trust to clarify the operational quality and safety governance structures and flows of assurance

required to support quality governance. The identified resources for quality governance are appropriate, and the Trust has plans in place to address gaps in resources. The agendas of Quality, Safety, and Performance Committee meetings are becoming more manageable and focussing on key matters. However, the timeliness of some data and information does not always support effective scrutiny.

Structured assessment

38 My 2022 structured assessment work took place at a time when NHS bodies were not only continuing to tackle the challenges presented by COVID-19 but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health.

39 My team focussed on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. Auditors also paid attention to progress made to address previous recommendations.

Governance arrangements

40 My work considered the Trust's governance arrangements, with a particular focus on:

- Board and committee effectiveness;
- the extent to which organisational design support supports good governance; and
- key systems of assurance.

41 My work found that **the Trust has good governance and leadership arrangements, supported by improving systems of assurance**.

42 The Trust's governance arrangements enable the Board and its committees to conduct their business effectively. Whilst the Board remains committed to openness and transparency, opportunities remain to improve the public availability of key papers and documents. There is good cross-referral of matters between committees and from committees to the Board. The quality of papers prepared for Board and committee meetings is improving, with reports beginning to draw attention more concisely to key matters for escalation or assurance.

43 The Trust has a stable Executive Team and organisational structure. Independent and Executive Board members continue to have a healthy relationship, which in turn facilitates informal and formal flows of information. Independent Members offer a good balance of challenge and support. Whilst corporate governance and risk management resources are lean, the Trust believes that current capacity, and also taking into account the plan for enhancing resourcing in 2023-4, is adequate. The

Trust continues to provide good Board training and development opportunities, and the Board actively pursues opportunities for self-reflection and improvement.

44 There has been extensive activity to renew and strengthen sources of assurance. The Trust's Assurance Framework is underpinned by appropriate risk management and performance management arrangements, which continue to develop and improve. The Trust has effective arrangements for overseeing information governance at a committee-level, but some operational arrangements require improvement. The Trust has also made a number of improvements to its arrangements for tracking internal and external audit recommendations.

Strategic planning arrangements

45 My work considered the Trust's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium-term Plan;
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

46 My work found that **the Trust has a clear strategic intent supported by good planning and stakeholder engagement arrangements. However, opportunities exist to enhance delivery reporting arrangements**.

47 The Trust's vision and strategic goals are clearly set out in its new ten-year strategy, 'Destination 2023'. The ten-year strategy is supported by a series of enabling strategies which focus on sustainability, people, digital, and estates. Collectively, they set a clear direction of travel for the organisation. The Trust produced a financially balanced Integrated Medium-Term Plan (IMTP) for 2022-25, which was approved by Welsh Government. The Board was actively involved in shaping and scrutinising the 2022-25 IMTP prior to formally approving and submitting it to Welsh Government.

48 The Trust has effective arrangements in place to oversee the development of corporate plans and strategies. The Trust is also effective at involving internal and external stakeholders in developing corporate strategies and plans. Whilst the 2022-25 IMTP sets out clear objectives and actions, the Trust needs to set out what successful delivery of the strategic priorities set out in the 2022-25 IMTP plans will look like, the outcomes it wants to achieve, and how these will be measured. The Trust has reasonably effective arrangements for reporting delivery of corporate plans and strategies. However, there is scope for reports to provide greater assurance to the Board that the Trust is taking appropriate action when delivery is off-track.

Managing financial resources

49 My work considered the Trust's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

50 My work found that **the Trust has effective arrangements for managing its financial resources but faces several risks to maintaining financial sustainability in the medium- to long-term**.

51 The Trust's arrangements for securing financial balance are good. The Trust met its financial objectives to breakeven in 2021-22 and over a three-year rolling period (2019-20 to 2021-22). The Trust is forecasting an overall breakeven position for 2022- 23. The Trust has a good understanding of its cost pressures which are clearly set out in its Strategic Financial Plan. However, these cost pressures alongside wider workforce costs and increased service demand may impede the Trust's ability to maintain financial sustainability in the medium- to long-term.

52 The Trust continues to have good controls for managing the use of its financial resources, with good reporting to the Audit Committee on procurement, losses, special payments, and counter-fraud matters. The Trust has good arrangements for monitoring and reporting financial performance. Finance reports provide timely and high-quality information, and support effective Board-level oversight, scrutiny, and challenge.

Managing the workforce, digital resources, the estate, and other physical assets

53 My work considered the Trust's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff wellbeing;
- arrangements for managing its digital resources; and
- arrangements for managing its estate and other physical assets.

54 My work found that **the Trust has clear plans in place to support staff well-being, harness the benefits of digital, and improve its estate. However, arrangements for monitoring and reporting on their outcomes require strengthening, particularly in relation to staff well-being and digital**.

55 Supporting staff well-being is a clear priority for the Trust. It has good arrangements in place to support the mental, physical, and financial well-being of staff. Whilst the Trust captures, monitors, and reports a range of staff related well-being activity, its arrangements for measuring and reporting the effectiveness of its well-being interventions require strengthening.

56 The Trust has a clear digital vision, which is set out in its Board-approved Digital Strategy. The strategy clearly sets out how digital technology and insight can support the drive to continually improve the quality, safety, experience, and

outcomes of services to meet the ambitions described in the Trust's wider ten-year strategy. There is good Board-level reporting on key digital projects and programmes and significant IT business continuity incidents. Whilst reports provide a good overview of progress, they do not provide an assessment of what difference digital projects and programmes are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended.

57 The Trust has a clear vision for its estates, which is set out in its Board-approved Estates and Sustainability Strategies. The Trust has an established process for prioritising competing capital cases, and the Board routinely receives business cases relating to significant capital projects and programmes for review, scrutiny, and approval. The Trust has effective arrangements in place for the Board and its committees to maintain appropriate oversight of matters relating to the estate in terms of health and safety, fire safety, and environmental and statutory compliance. However, the Trust has an aging estate to manage in terms of the current Velindre Cancer Centre and there is a programme of work to upgrade Welsh Blood Service facilities. Significant preparatory work towards building the new Velindre Cancer Centre is now being progressed. There will be a challenge, in the short- to medium-term, to achieve an appropriate balance between maintaining the existing estate whilst investing in the future estate.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Trust in 2022.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	13 June 2022
Opinion on the Financial Statements	13 June 2022
Audit of Accounts – Addendum Report	19 July 2022
Charitable Funds – Audit of Financial Statements Report	19 January 2023
Performance audit reports	
Review of Quality Governance Arrangements	August 2022
Structured Assessment 2022	January 2023
Other	
2022 Audit Plan	April 2022

My wider programme of national value for money studies in 2022 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts

Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are a number of performance audits that are still underway at the Trust. These are shown in the following table, with the estimated dates for completion of the work.

Report	Date
Review of workforce planning arrangements	March 2023
2022 Local Work	TBC

Appendix 2

Audit fee

The 2022 Audit Plan set out the proposed total audit fee of £238,783 (excluding VAT). My latest estimate of the actual fee is in keeping with the fee set out in the outline.

In addition to the fee set out above, the audit work undertaken on the shared services provided to the Trust by the NHS Wales Shared Services Partnership cost £2,154.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2022 Audit Plan set out the risks for the audit of the Trust's 2021-22 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
Management Override The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	Planned audit work completed and no issues arising.
Inventory balance Our 2020-21 audit opinion was qualified as we did not attend any of the Trust's stock takes. The Trust, through NWSSP, continue to have an integral role in procuring and distributing Personal Protective Equipment, particularly to NHS Wales bodies and social care providers,	We will attend a number of stock counts at a number of the stores facilities operated by the Trust and develop additional audit procedures to obtain assurance that the inventory balance within the financial statements is materially correct.	Various audit procedures where undertaken, including attending a number of stock counts, and sufficient assurance was obtained upon both the year-end inventory balance.

Audit risk	Proposed audit response	Work done and outcome
in response to the pandemic. Whilst a reduction in the year-end inventory balance is expected within the 2021-22 financial statements the value of the stock holdings will continue to be material. A number of related audit risks exist, particularly in regard to our need to obtain sufficient audit assurance upon: • the 2021-22 opening inventory balance; • the 2021-22 stock taking arrangements and final inventory balance; • stock donations to assist countries and the associated accounting treatment; and • any valuation adjustments concerning obsolete or slow-moving stock have been appropriately considered in calculating the year-end balance.		
NHS pension tax liabilities The implementation of the 'scheme pays'	We will review the evidence one year on around the take-up of the scheme and the need for	The Trust included a provision of £377,000 relating to NHS Clinicians' pension tax liabilities. This

Audit risk	Proposed audit response	Work done and outcome
initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money. This would then result in the qualification of our regularity opinion.	a provision, and the consequential impact on the regularity opinion.	was deemed to be outside the Trust's powers and so a qualified regularity opinion was issued.
Break even duty NHS Trusts have a financial duty to break even over a three-year rolling period. Although the Trust is forecasting a break-even position, this duty increases the risk that management judgements and estimates included in the financial statements could be biased in help achieve this financial duty. Where the Trust fails this financial duty, I will place a substantive	The audit team will focus its testing on areas of the financial statements which could contain reporting bias.	The Trust achieved its break-even duty – no issues arising.

Audit risk	Proposed audit response	Work done and outcome
report on the financial statements highlighting the failure.		
Capital expenditure The Trust has purchased Matrix House during 2021-22 and expenditure has continued to be incurred in relation to construction of the new Velindre Cancer Centre. There is a risk that the related capital expenditure has not been appropriately accounted for within the financial statements.	We will monitor the position as part of our ongoing audit work and review the accounting treatment within the financial statements.	No issues arising.
NHS Wales Informatics Service / Laundry There have been two significant changes in regard to the functions hosted by the Trust during 2021-22. NHS Wales Informatics Service transferred from the Trust to form Digital Health and Care Wales on 31 March 2021, and laundry functions have transferred to the Trust from a number of Health Boards.	We will review the accounting treatment and disclosures in relation to these transfers.	No issues arising.

Audit risk	Proposed audit response	Work done and outcome
IFRS16 Introduction of IFRS 16 Leases has been deferred until 1 April 2022. There may be considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	We will review the completeness and accuracy of the disclosures.	No issues arising.
Covid 19 There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. These could have an impact on the risks of misstatement and the shape and approach to our audit.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.	No issues arising.
Covid-19 – qualitative issues Although COVID-19 restrictions have now been removed, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.	The draft accounts and supporting working papers were of good quality. Neither were any material adjustments made to the financial statements as a result of our audit.

Audit risk	Proposed audit response	Work done and outcome
accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.		

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Structured Assessment 2022 – Velindre University NHS Trust

Audit year: 2022

Date issued: March 2023

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

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2022 structured assessment work at Velindre University NHS Trust (the Trust). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004.

2 Our 2022 Structured Assessment work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to the public and key stakeholders that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. We have not reviewed the Trust's arrangements for hosting the NHS Wales Shared Services Partnership as part of this work. The approach we adopted to deliver our work is detailed in summarised in **Appendix 1**.

4 We have also provided updates on progress against recommendations identified in previous structured assessment reports.

Key messages

5 Overall, we found **that the Trust is generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance, and effective arrangements for managing its finances and other resources.**

6 The Trust's Board and its committees continue to operate effectively and are actively using learning to drive improvement. However, opportunities remain to improve the public availability of key papers and documents on the Trust's website. The Trust continues to have a stable Executive Team and organisational structure. It has reviewed and strengthened its systems of assurance which should enable the Board and its committees to assess and improve organisational performance and effectiveness once fully operational. However, it needs to reinstate the log for

tracking recommendations relating to the quality and safety of services made by external inspection and regulatory bodies.

7 The Trust has good planning and stakeholder engagement arrangements. It has a clear strategic vision, supported by goals and objectives, which the Trust articulates in its new ten-year strategy (Destination 2032), enabling strategies, and Welsh Government approved 2022-25 Integrated Medium-Term Plan (2022-25 IMTP). However, whilst the Trust's strategic priorities as set out in the 2022-25 IMTP, are specific, measurable and timebound, they do not set out the intended outcome. Whilst reporting on delivery of the 2022-25 IMTP is good, opportunities exist to strengthen reports to provide greater detail on whether the intended outcome has been achieved.

8 The Trust has effective arrangements for managing its financial resources and continues to meet its financial duties. However, the Trust is aware that it faces risks to maintaining financial sustainability in the medium- to long-term. Financial controls are effective, and the Trust continues to produce clear and accessible financial reports to support effective monitoring and scrutiny.

9 Staff well-being continues to be a priority for the Trust. But its arrangements for measuring and reporting on the effectiveness of well-being interventions require strengthening. The Trust has ambitious plans in place to harness the potential of digital to transform service delivery, but some plans remain uncosted. Furthermore, arrangements for monitoring and reporting on the benefits of digital require strengthening. The Trust has a clear vision for its estates and environmental sustainability and has good arrangements in place for ensuring Board-level oversight and scrutiny of key estates related risks and matters.

Recommendations

10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 2**. [**Appendix 2** will be completed once the report and organisational response have been considered by the relevant committee.]

Exhibit 1: 2022 recommendations

Recommendations
Improving administrative governance arrangements
R1 We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing:

Recommendations

- missing committee meeting papers;
- the Register for Gifts, Hospitality and Sponsorship and the Declarations of Interest Register; and
- 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.

Reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies

R2 The Quality, Safety, and 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.

Establishing measurable outcomes for strategic priorities

R3 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.

Enhancing reporting on 2022-25 IMTP delivery

R4 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.

Improving reporting on the benefits arising from digital investments

R5 Whilst there is good reporting on progress in delivering key digital projects and programmes, the reports do not provide an assessment of what difference they are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.

Detailed report

Governance arrangements

11 In this section of the report, we provide our views on the Trust's governance arrangements, with a particular focus on:

- Board and committee effectiveness;
- the extent to which organisational design supports good governance; and
- key systems of assurance.

12 Details of progress made on previous year recommendations relating to the Trust's governance arrangements are provided in **Exhibit 2** and **Exhibit 3.**

13 We found that **the Trust has good governance and leadership arrangements, supported by improving systems of assurance.**

Board and committee effectiveness

14 We considered the extent to which the Board and its committees conduct their business effectively and support good governance. In examining this, we have looked at whether:

- the Board and its committees demonstrate appropriate levels of public transparency;
- meetings are conducted appropriately supported by clear Schemes of Delegation, Standing Orders, Standing Financial Instructions, and Registers of Interest;
- there is an appropriate and well-functioning committee structure below the Board;
- the Board and its committees receive the right information, including views from staff and service users; and
- there is evidence of sufficient self-review by the Board and its committees.

15 We found that **the Board and its committees operate effectively and are actively using learning to drive improvement. However, opportunities remain to improve the public availability of key papers and documents.**

16 The Trust continues to demonstrate appropriate levels of public transparency. All public Board meetings are live-streamed to allow the public to observe virtually, with recordings made available on the Trust's website (see **Exhibit 2, 2021 R1**). The Trust, however, does not live-stream or record its committee meetings. The Trust minimises the use of private sessions, reserving these for confidential and sensitive matters only. Where it uses private sessions, the Trust publishes the 'minutes' on its website.

17 The Trust continues to circulate Board and committee papers to attendees in advance of meetings. However, the Trust does not always publish these on its website in advance of meetings and within the required timescales set out in the Standing Orders (**Recommendation 1**). For instance, the Trust did not publish

papers for the 4 October 2022 Audit Committee and the 13 October 2022 Strategic Development Committee prior to the meetings (see **Exhibit 2**, **2021 Rec 1**). We also found that the papers for some committee meetings were still missing from the Trust's website long after they had occurred. A review of the Trust website (30 November 2022) found that the following committee papers were still not available:

- January, May, and October 2022 Audit Committee papers;
- January, February, and March 2022 Quality, Safety, and Performance Committee papers; and
- October 2022 Strategic Development Committee papers.

18 The organisation's governance arrangements support the effective conduct of Board and committee business. The Trust appropriately reviews its Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions on a frequent basis. It last updated the Standing Orders in January 2022, which included new terms of reference for four committees. It received Board approval in January 2022 following scrutiny by the Audit Committee. The Standing Orders and Standing Financial Instructions are available on the Trust website, and reflect the changes made in January 2022. The Audit Committee receives the Register for Gifts, Hospitality and Sponsorship and the Declarations of Interest Register on a quarterly basis, which it last reviewed in October 2022. Whilst these registers are available in Audit Committee papers, the Trust has not published them separately on its website (**Recommendation 1**). We routinely observe declarations of interest taken at the start of Board and committee meetings as a standing item on all agendas.

19 The Trust continues to have a stable Board. Two new Independent Members assumed their posts in August and November 2021. In general, Independent Members' terms are staggered, which minimises Board instability and helps reduce the risk of losing knowledge and experience when terms end. We found that Independent and Executive Board members continue to have a healthy relationship, which in turn facilitates informal and formal flows of information. We have observed Independent Members offering a good balance of challenge and support. From our observations, we note that Independent Members often scrutinise officers on the impact of decisions on patients and donors. We have observed robust scrutiny of waiting time performance for patient referrals for Systematic Anti-Cancer Treatment and Radiotherapy.

20 The Trust has a streamlined Board and committee structure, which appropriately reflects the organisation's business. The Board committee structure is well embedded and there is a commitment to review and amend, as necessary. The Trust reviewed its committee structure in March 2022, and there are plans to undertake a more detailed review of the effectiveness of committees during 2023.

21 The Trust has kept virtual Board meetings under review as COVID-19 restrictions have started to relax. In May 2022, it began a phased return to face-to-face meetings by holding a 'hybrid' Board meeting, with some members attending in-person and others attending virtually. Subsequent Board and committee meetings

have adopted this model, and these generally work well. Moving forward, the Trust envisages continuing with a hybrid model. We found that Board and committee meetings are well chaired, and members continue to observe good virtual etiquette.

22 There is good cross-referral of matters between committees and from committees to the Board. Cover reports clearly identify where papers have previously been scrutinised by a committee, and meeting chairs helpfully remind attendees of this to help avoid unnecessary repeat discussions. There is a shared intent to ensure that, in future, cover papers also include a summary of previous discussions, and that the Trust reflects the resulting agreed actions in papers. The Trust also intends to look at the scheduling of committee meetings to ensure Executive Directors have sufficient time to action any agreed changes to agenda items prior to them being considered for approval at a later meeting, where this applies.

23 In our 2021 structured assessment report, we found that the Quality, Safety, and Performance Committee agenda items often went into too much detail. The Trust fully recognises this view. Our review of the Trust's quality governance arrangements (reported in August 2022) found improvements during 2022, with committee meetings running to time, and more focused discussions on key matters. Once fully operationalised, the new Quality and Safety Governance Group should help further by triangulating and refining exception reporting to committee, and play a role in ensuring that the detail of committee papers is pitched correctly. The Trust recognises there is more work to do. It has set out further improvements in an action plan to address findings from the Quality, Safety, and Performance Committee's annual effectiveness review. There are also additional relevant actions set out in the Quality and Safety Framework Implementation Plan.

24 Our observations of the Board and committee meetings in summer and autumn 2022 have found that cover reports and verbal presentations are beginning to draw attention more concisely to key matters for escalation or assurance. The Trust fully recognises there is more work to do to ensure that discussions in all Board and committee meetings do not become impeded by too much detail in papers and cover reports. It is also encouraging to note that Trust is working to try and better triangulate workforce, performance, and finance information.

25 The Trust continues to provide good Board training and development opportunities and seeks opportunities for further improvements. The Board is required to undertake an annual self-assessment of its effectiveness. The Board concluded in its Accountability Report 2021-22 that it could define itself as "having well developed plans and processes and can demonstrate sustainable improvement throughout the organisation" and scored itself a four out of a possible five. The Trust is one of only two NHS bodies in Wales that uses this maturity assessment.

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

commence with either a patient, a donor, or a staff story, which usefully sets the tone for the remainder of the meeting.

27 The Trust is engaging with staff across the organisation to understand how they feel and to address findings from the 2021 NHS Staff Survey. The Trust intends that the outputs of this work give a picture of the culture of the organisation and inform the next iteration of the Trust Behaviours and Values.

Exhibit 2: progress made on previous year recommendations

Recommendation	Description of progress
Transparency of Board business 2021 R1 Some committee meeting papers are missing from the website, as are links to recordings of Board meetings. The Trust should ensure that it strengthens the process for the collation, sign off and timely publication of: • Board and committee meeting papers; and • recordings of Board meetings.	**Superseded** Our review found that recordings of most Board meetings are available on the Trust website. Similarly, the Trust ensures that Board papers are available in advance of meetings. However, we found that the Trust has not published some committee papers in advance of meetings, and some remain unpublished long after the meeting date. As a result, this recommendation is superseded by a new recommendation (see **Exhibit 1 – R2 Improving administrative governance arrangements**).

Organisational design

28 We considered the extent to which the Trust's organisational structure supports effective governance. In examining this, we have looked at whether:

- the responsibilities of Executive Directors are clear, and that they have balanced and equitable portfolios of work;
- there is clarity on the role of the Board Secretary, and there are adequate resources in place to support the work of the Board and its committees; and
- the organisational structure supports effective governance and facilitates whole-system working.

29 We found that the **Trust has a stable Executive Team and organisational structure.**

30 The Trust continues to have a stable Executive Team and organisational structure. Executive portfolios are appropriate and balanced. The role of Board Secretary is undertaken by the Director of Corporate Governance and Chief of Staff. Whilst

corporate governance and risk management resources are lean, the Trust told us that current capacity is adequate.

31 Due to the small size of the organisation, the Trust recognises it has limited capacity to support service improvement and transformational work programmes. The Executive Management Team has recently contracted an external consultant to design a prioritisation framework for core service delivery improvements and transformational activity. The Trust intends to use these outputs to populate and prioritise a roadmap of work programmes to inform the development of the 2023-26 IMTP. The Trust recognises it needs to ensure that the roadmap matches available capacity and that it puts sufficient change management capability in place to support delivery.

Systems of assurance

32 We considered the extent to which the Board and its committees oversee, scrutinise, and challenge organisational risks, performance, and quality of services. In examining this, we have looked at whether:

- there is an effective Board Assurance Framework (BAF) in place, which is actively reviewed and owned by the Board;
- the BAF is underpinned by appropriate systems for managing risks and performance; overseeing the quality and safety of services; and handling information in a secure manner; and
- effective action is taken to address audit and review findings and recommendations.

33 We found that **there has been extensive activity to renew and strengthen sources of assurance. Once fully operational, these sources of assurance should provide good coverage to enable the Board and its committees to assess and improve organisational performance and effectiveness.**

34 We considered the Trust Board Assurance Framework (TAF) and risk management arrangements as part of our review of the organisation's quality governance arrangements (reported in August 2022).

35 As part of our quality governance review, we said that Board committees need to review strategic risks more methodically. Committees, as part of their cycles of business, should consider the controls and gaps in assurance outlined in the TAF and receive and monitor progress against associated action plans. To date, scrutiny of the TAF has concentrated on its development, rather than the content. However, in November 2022, the Trust assigned each strategic risk to a committee and set out that each one would consider their cycle of business to ensure appropriate consideration of the associated controls and sources of assurance. The Trust plans to enhance the TAF by incorporating links to risks within the Corporate Risk Register, key performance measures, and audit recommendations. It also plans to further develop the articulations of strategic risks to ensure they align with the priorities set out in the 2023-26 IMTP (see **Exhibit 3**, **2019 R2**).

36 In our quality governance review, we also reported that whilst the Trust had made progress to develop and improve risk management arrangements during 2020 and 2021, there were still outstanding areas of work. We found that risk registers presented to meetings do not always include enough information to allow good scrutiny and challenge. We recommended that the Trust should determine what information it needs to include in all risk registers (including the Corporate Risk Register) to enable good management and scrutiny. This should, for example include opening, current and target risk scores, and provide sufficient clarity on existing controls and effectiveness of mitigating actions.

37 The Trust has made positive progress with its operational risk management arrangements since our quality governance review. It has completed the migration of Welsh Blood Service risks to the new version of DATIX[1] and approved amendments to the Risk Management Framework (see **Exhibit 3**, **2016 R7c**). Rollout of risk management training continues. A review of the information contained in risk registers is underway. Work is in progress to address risk management recommendations set out in our quality governance review and Internal Audit's 2021 Board Assurance Framework report. However, it is too early to assess the effectiveness of these arrangements and whether they are helping to reduce risk scores (see **Exhibit 3**, **2019 R2**).

38 In our quality governance review, we found that there has been considerable progress to improve governance arrangements for quality and safety, with the approval of a new Quality and Safety Framework in July 2022. However, it was too early to assess the effectiveness of new arrangements in practice.

39 The Trust is in the process of revising and enhancing its performance management arrangements. It is developing a 'balanced scorecard' approach aligned to six domains of care – safe, effective, service user centred, timely, efficient, and equitable care. There will be specific performance scorecards for the Board; the Quality, Safety, and Performance Committee; the Executive Management Board; and the divisional senior management teams. The proposed approach is based on a hierarchy of performance measurements appropriate to the remit and scrutiny requirements at each organisational level. This will allow the Trust to develop a broader range of performance measures, such as the inclusion of more outcome measures. The Board will take assurance from the detailed review and challenge undertaken by each level below. The Trust intended that the Quality, Safety and Performance Committee and Board would receive the new and revised performance reports at the planned November 2022 meetings. However, it did not achieve this target due to operational pressures. Despite this, the Trust's performance management arrangements are helping to provide operational focus to improve performance.

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

40 The Trust has effective arrangements for overseeing information governance at a committee-level, but some operational arrangements require improvement. In 2020, Internal Audit completed a baseline review of the arrangements in place for the management and control of information governance and information communications technology using the COBIT 2019 Framework[2]. As part of their assessment, Internal Audit scored the Trust's arrangements under each of the headings of the framework. The Trust scored well under many of the headings but particularly well in its information governance arrangements (94%). In terms of cyber security, the Trust scored 61% and 71% for managed security and managed security services, respectively. Internal Audit highlighted several opportunities for the Trust to strengthen its cyber security arrangements and will complete a further review of these arrangements by March 2023. The Quality, Safety, and Performance Committee receives information governance assurance reports on a quarterly basis, which provide a good overview of the Trust's activities in relation to data protection, physical security, and information security. At 82.59%, the Trust's compliance against mandatory information governance training is only slightly below the NHS Wales target of 85%[3].

41 Improvements have been made to the Trust's arrangements for tracking internal and external audit recommendations. An Internal Audit review of the Trust's audit trackers in 2022 highlighted that the organisation did not have a procedure note in place to set a standard for responding to internal and external audit recommendations. The Trust subsequently developed a draft procedure which the Audit Committee endorsed in July 2022. The Audit Committee now reviews the full tracker twice a year and considers overdue and completed actions for closure at each meeting (see **Exhibit 3**, **2018 R4b**). Prior to the pandemic, the Quality, Safety, and Performance Committee received a tracker for recommendations made by other external inspection and regulatory bodies, such as Healthcare Inspectorate Wales. However, the committee has not received the tracker since early in 2020 (**Recommendation 2**).

[2] COBIT (Control Objectives for Information and Related Technologies) is an IT management framework developed by the Information Systems Audit and Control Association to help organisations develop, organise, and implement strategies around information management and governance.

[3] As reported in the July 2022 Information Governance Assurance Report to the Quality, Safety, and Performance Committee.

Exhibit 3: progress made on previous year recommendations

Recommendation	Description of progress
Risk management **2016 R7c** The Trust should standardise the format of its various risk registers, ensuring the good practice elements of each register are spread across the organisation.	**Complete** The Trust has completed the migration of all risk registers to DATIX.
Board assurance and risk management **2019 R2** The Trust should complete the development of its Board Assurance Framework with pace, ensuring that it is appropriately underpinned by up-to-date risk management arrangements. Specifically, the Trust should • review the principal risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new Board Assurance Framework; • update the Risk Management Framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; and • provide risk management training to staff and Board members on resulting changes to the risk management framework	**On-track, but not complete** The Trust has populated its Assurance Framework with strategic risks, and it intends to review these risks to ensure they align with the Integrated Medium-Term Plan. The Trust has updated its Risk Management Framework and Risk appetite, with the former articulating the escalation arrangements. The one outstanding area is the rollout of risk management training, which is not yet complete.
Tracking Internal and External audit recommendations **2018 R4b**	**Complete** There is a mechanism in place for Audit Committee to agree to the closure of recommendations.

Recommendation	Description of progress
Implement a mechanism for ensuring that when Internal Audit and External Audit actions are completed, the responsible officer provides a brief summary of the actions taken to the Audit Committee, along with a request to close the action	
Clinical audit scrutiny **2018 R5a** The Quality and Safety Committee should review and approve clinical audit plans, ensuring that clinical audit plans address any risks to achieving strategic priorities and organisational risks.	We have not considered these recommendations as part of our 2022 structured assessment work as Internal Audit will be undertaking a clinical audit review. We will, therefore, consider them as part of our 2023 structured assessment work.
Clinical audit scrutiny **2018 R5b** Improvements should be made to the content of clinical audit reports from both VCC and WBS to clearly identify the audit findings, any associated risks and actions for improvement and follow-up.	
Clinical audit scrutiny **2018 R5c** The Quality and Safety Committee should assure itself that clinical audit findings are addressed.	
Clinical audit scrutiny **2018 R5d** Clinical audit scrutiny The Audit Committee should clarify how it assures itself that the clinical audit function is effective	

Strategic planning arrangements

42 In this section of the report, we provide our views on the Trust's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium-term Plan;
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

43 Details of progress made on previous year recommendations relating to the Trust's strategic planning arrangements are provided in **Exhibit 4**.

44 We found that **the Trust has a clear strategic intent supported by good planning and stakeholder engagement arrangements. However, opportunities exist to enhance delivery reporting arrangements.**

Vision and strategic objectives

45 We considered the extent to which there is a clear vision and long-term strategy in place for the organisation. In examining this, we have looked at whether:

- the vision and strategic objectives are future-focussed, and rooted in a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- the vision and strategic objectives have been developed and adopted by the Board; and
- the long-term strategy is underpinned by an appropriate long-term clinical strategy.

46 We found **that the Trust has a clear vision and goals in its long-term strategy, supported by a suite of enabling strategies.**

47 The Trust's vision of 'Excellent Care, Inspirational Learning, Healthier People' is clearly set out in its new ten-year strategy, 'Destination 2032'. The strategy has five clear strategic goals which seek to address post-pandemic opportunities, challenges, and risks. Destination 2032 is supported by a series of enabling strategies, one each for sustainability, people, digital, and estates. Destination 2032 was approved by the Board in July 2022, and the enabling strategies in May. Whilst these strategies are available in Board papers, they are not published separately on the Trust's website (**Recommendation 1**).

48 The pandemic caused a delay to completing Destination 2032 and the enabling strategies, but work recommenced in 2021. Board members were actively involved in developing the strategies, and the Trust engaged well with a broad range of internal and external stakeholders as part of the planning process. Destination 2032, along with the enabling strategies, set a clear direction of travel for the organisation.

49 The Trust has separate strategies for Velindre Cancer Centre and the Welsh Blood Service, which are both framed in the context of Destination 2032. The Trust has delayed the establishment of a Clinical and Scientific Strategy Board while it determines the resources required to support these arrangements. The Executive Management Board has agreed the terms of reference for the Clinical and Scientific Board. The Trust recognises that it needs to establish the Clinical and Scientific Strategy Board without further delay to provide a formal route for clinicians to inform the development of its clinical and scientific plans and work in areas such as value-based healthcare, National Clinical Framework requirements, and the Duties of Candour and Quality.

Planning arrangements and the Integrated Medium-Term Plan

50 We considered the extent to which the Trust has been able to produce an approvable Integrated Medium-Term Plan (IMTP) for 2022-2025. We also considered the extent to which the Board maintains effective oversight of the process for developing corporate strategies and plans. In examining this, we have looked at whether:

- the IMTP was submitted within the required timeframes in line with Welsh Government guidance;
- the draft and final versions of the IMTP were discussed, challenged, and agreed by the Board prior to submission;
- the IMTP received approval from the Minister for Health and Social Services;
- the extent to which the Board maintains effective oversight of the process for developing corporate strategies and plans;
- whether corporate strategies and plans have been developed in liaison with relevant internal and external stakeholders; and
- whether prudent and value-based healthcare principles are considered and reflected in corporate strategies and plans.

51 We found that **the Trust has good planning arrangements. It also has an approved IMTP, which received appropriate Board-level input and scrutiny.**

52 The Trust was able to produce a balanced and Welsh Government approved IMTP for 2022-25 (the 2022-25 IMTP). The 2022-25 IMTP, which was prepared in accordance with Welsh Government planning guidance, describes the operating context, identifies the key factors influencing the priorities within the plan, and has appropriate coverage of the Trust's operations for the three-year period. The 2022-25 IMTP is available on the Trust's website.

53 An assessment of demand for blood and cancer services by commissioning Health Boards has also helped to inform the 2022-25 IMTP. However, demand for cancer services was higher than planned during 2022 due to ongoing impacts resulting

from the pandemic[4]. In addition, capacity for radiotherapy and Systematic Anti-Cancer Treatments is reduced due to factors including workforce pressures, the need to maintain social distancing, and ageing radiotherapy equipment 'downtime'. The Trust had planned to commission external capacity, but this option became unfeasible. The Trust has demonstrated flexibility in its planning arrangements to secure additional capacity via increasing workforce, equipment, and physical spacing. The Trust's actions are having a positive impact on waiting times in the latter stages of 2022.

54 There was good Board-level engagement throughout the development of the 2022-25 IMTP. The Strategic Development Committee provided appropriate scrutiny of the planning arrangements on behalf of the Board. We found that the Board and the Strategic Development Committee effectively scrutinised and challenged the 2022-25 IMTP prior to its submission. The Board formally approved the 2022-25 IMTP in March 2022 and submitted to Welsh Government within the required timeframe. The Minister for Health and Social Services approved the 2022-25 IMTP in July 2022 and set out accountability conditions which the Trust is actively addressing.

55 The Trust has effective planning arrangements. The planning process is co-ordinated by the Trust's Strategic Planning Team. They are supported by planning managers in each division as well as the finance team, and overseen by the Executive Management Board. The Trust is also effective at involving internal and external stakeholders in developing corporate strategies and plans. There is evidence of good engagement with the Community Health Council, commissioners, patients, donors, and other stakeholders in developing Destination 2032 and the supporting enabling strategies, and the 2022-25 IMTP.

56 The 2023-26 IMTP will set the context and actions to deliver the Trust's new vision and strategic goals. In addition, the work to prioritise improvement and transformation plans will help shape the 2023-26 IMTP (see **paragraph 31**). The 2023-26 IMTP will also need to set out the challenges, risks, and opportunities relating to the set up and running of the new Velindre Cancer Centre, including cost pressures and uncertainties associated with planning assumptions.

57 The Trust recognises that it is at an early stage in its value-based healthcare journey. It has a clear set of priorities and an implementation plan to guide its approach to embedding value-based healthcare across the organisation. Recent funding from Welsh Government should enable the Trust to move at pace to deliver on its ambitions by increasing capability and expertise in this area. This should also allow the Trust to ensure that value-based healthcare principles inform the Trust's overall approach to strategic planning.

[4] During the earlier phases of the pandemic screening for cancer was lower than 'normal' levels, meaning that there was an element of catch-up occurring during 2022, in addition where patients are presenting later, cancer can be more progressed and requiring more intensive treatment.

Implementation and monitoring arrangements

58 We considered the extent to which the Board oversees, scrutinises, and challenges the implementation and delivery of corporate strategies and plans. In examining this, we have looked at whether:

- corporate strategies and plans contain clear milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board receives regular reports on progress to deliver corporate strategies and plans.

59 We found that **whilst the IMTP contains clear objectives and actions, supported by timescales for delivery, it lacks supporting intended measurable outcomes. Progress reporting is reasonably effective, but reports should provide greater assurance that the Trust is taking appropriate action when delivery is off-track.**

60 In the 2022-25 IMTP, the Trust has set out its strategic priorities for the three years covered by the plan. Each strategic priority is translated into specific objectives and actions, with timescales for delivery. However, the Trust should better articulate what successful delivery of the strategic priorities set out in the 2022-25 IMTP will look like, the outcomes it wants to achieve, and how these will be measured (**Recommendation 3**). The benefit of doing so is to demonstrate that in delivering an action, the Trust has achieved the intended outcome, and if not, that further action may be necessary. We recognise it is difficult for the Trust to demonstrate the direct impact of its work on cancer service patient outcomes, especially as these are affected by factors outside its control. Nonetheless, this is an important part of demonstrating the Trust's impact of improving cancer patient outcomes.

61 The Trust has reasonably effective arrangements for reporting delivery of the 2022-25 IMTP. Officers presented the Quarter 1 and Quarter 2 2022-2023 progress report to the Board in November 2022, which used Red, Amber, Green (RAG) ratings to highlight progress. There was a good discussion in the Board meeting on additional information that would be useful to include in future reports to support scrutiny. For example, where delivery is off-track, reports should explain the reasons why and the remedial action needed and / or actions in-progress. In our view, there is also scope to provide greater detail on the impact of actions delivered to date (see **paragraph 60**), and the extent to which limited service improvement and change management capacity is inhibiting delivery (see **paragraph 31**). This would allow the Trust to understand the effectiveness of its actions and assess which actions it either needs to revise or roll forward to the 2023-26 IMTP (**Recommendation 4**). Going forward, the Quality, Safety, and Performance Committee will play a greater role in reviewing and monitoring progress in more detail.

Exhibit 4: progress made on previous year recommendations

Recommendation	Description of progress
Articulation of strategic priorities 2021 R2 Not all the Trust's strategic priorities in the Annual Plan are supported by specific, timebound actions for delivery, and the intended outcome. In future, the Trust should ensure that all strategic priorities are supported by discrete objectives, each underpinned with specific, timebound actions for delivery and the intended outcome.	**Superseded** In the 2022-25 IMTP, strategic priorities are supported by specific, measurable and timebound actions for delivery, but they lack intended outcomes. This recommendation is superseded by a new recommendation (see **Exhibit 1 - R3 Establishing measurable outcomes for strategic priorities**.)

Managing financial resources

62 In this section of the report, we provide our views on the Trust's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

63 We found that **the Trust has effective arrangements for managing its financial resources but faces several risks to maintaining financial sustainability in the medium- to long-term.**

Financial objectives

64 We considered the extent to which the Trust has effective arrangements in place to meet its key financial objectives. In examining this, we have looked at whether the Trust:

- met its financial objectives for 2021-22, and is on course to meet its financial duties in 2022-23; and
- has a clear and robust financial plan in place, which includes realistic and sustainable savings and cost improvement plans.

65 We found that **the Trust met its financial duties for 2021-22 and has a clear financial plan to deliver services in 2022-23.**

66 The Trust met its financial duties in 2021-22, reporting a small surplus of £41,000 at the end of the financial year. The Trust also achieved its statutory financial duty

to achieve break-even over a three-year rolling period (2019-20 to 2021-22), reporting an overall three-year surplus of £103,000.

67 The Trust's 2022-25 IMTP is underpinned by a comprehensive Strategic Financial Plan. The plan is based on a clear series of assumptions regarding the Trust's expected income from its commissioners and Welsh Government funding to support recovery from the COVID-19 pandemic, the cost pressures facing the Trust in terms of pay and non-pay inflation, and the cost saving potential of services. Financial risks to the successful delivery of the plan are clearly set out, as well as the actions the Trust is taking to manage and mitigate against them.

68 For 2022-23, the Trust has set a savings requirement of £1.3 million (a 2% target), of which £800,000 is recurrent and £500,000 non-recurrent. Of the £1.3 million, £750,000 are savings schemes and £550,000 are income generating schemes. As of Month 6 2022-23, the Trust reported that the ongoing implications of the pandemic and increased prices caused by current market conditions will impact on saving scheme delivery. As a result, the Trust has asked that where there is risk to delivery of savings, alternative savings and cost reductions are identified and implemented to ensure that the overall targets are met.

69 As of Month 6 2022-23, the Trust reported that it is on course to achieve financial balance by the end of the financial year. However, this assumes that:

- Welsh Government and the Trust's commissioners will fully reimburse all additional COVID-19 costs along with exceptional national cost pressures;
- that the Trust receives all other planned additional income; and
- that the Trust achieves its savings targets.

Financial controls

70 We considered the extent to which the Trust has appropriate and effective arrangements in place for allocating, authorising, recording, and managing the use of its financial resources. In examining this, we have looked at whether:

- there are effective controls in place to ensure compliance with Standing Financial Instructions and Schemes of Delegation;
- the Audit Committee maintains appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- there are effective financial management arrangements in place; and
- financial statements were submitted on time, contained no material misstatements, and received a clean audit opinion.

71 We found that **the Trust continues to have good controls for managing the use of its financial resources.**

72 The Trust continues to have effective controls in place to ensure compliance with its with Standing Financial Instructions and Scheme of Reservation and

Delegation. Since our last structured assessment report, Internal Audit has issued reasonable assurance ratings on the Trust's:

- financial systems relating to non-pay expenditure, fixed assets, and debt management (reported in May 2022);
- arrangements for scrutinising expenditure above the Chief Executive's limit (£100,000) (reported in May 2022); and
- processes underpinning financial and service sustainability, namely budgetary control (revenue budgets) and savings plans (reported in October 2022).

We did not identify any significant control weaknesses from our review of the Trust's 2021-22 financial statements.

73 The Trust continues to report regularly to the Audit Committee on procurement, losses, special payments, and counter-fraud matters to support effective oversight, scrutiny, and challenge. Procurement reports continue to clearly set out the number of Single Tender Actions and Single Quotation Authorisations and the reasons why officers did not follow standard procurement procedures. The value and reasons for deviation from standard procurement procedures also continue to be clearly set out in these reports. The Trust has recently enhanced these reports to provide additional context for members of the Audit Committee, and further improvements are planned by the Trust's new Head of Procurement to strengthen the assurances provided.

74 The Trust continues to log urgent decisions taken by the Chair between scheduled Board meetings. All urgent decisions are subsequently presented to the Board in writing for scrutiny and ratification.

75 The Trust has a good understanding of its cost pressures which are clearly set out in its Strategic Financial Plan. These include energy and fuel cost increases, the Employers National Insurance uplift (which was subsequently repealed by the UK Government), the living wage, and other extraordinary levels of cost inflation. However, these cost pressures alongside wider workforce costs and increased service demand may impede the Trust's ability to maintain financial sustainability in the medium- to long-term.

76 Financial management arrangements are effective. The Trust has set clear budgets and savings targets for each of the divisions and enabler functions. At Month 6 2022-23, the reported financial position of all divisions and enabler functions was breakeven (noting a small underspend in Corporate Services), and an expected outturn position of breakeven.

77 The Trust submitted good quality draft financial statements for audit by the Welsh Government imposed deadline of 29 April 2022. The Audit Committee considered these on 13 June 2022. Our audit identified no material misstatements, and we

issued an unqualified audit opinion, except for the regularity opinion, for which we issued a qualified opinion[5].

Monitoring and reporting arrangements

78 We considered the extent to which the Board oversees, scrutinises, and challenges the organisation's financial performance. In examining this, we have looked at whether:

- reports to the Board provide a clear picture of the organisation's financial position, as well as the key financial challenges, risks, and mitigating actions taken; and
- Board members sufficiently challenge ongoing assessments of the financial position.

79 We found that **the Trust continues to produce clear and accessible financial reports that support effective monitoring and scrutiny**.

80 The Trust continues to report financial performance at every public Board meeting and Quality, Safety, and Performance Committee meeting. The Trust publishes this information on its website alongside its Board and committee papers. The finance reports provide timely and high-quality information and contain a good mixture of text and exhibits to convey key messages. The reports set out the revenue, capital, and savings position of the Trust, and clearly highlights key financial risks with their associated mitigating actions and cost implications. We have observed good scrutiny and challenge around the organisation's financial position at both Board and Quality, Safety, and Performance Committee meetings.

Managing the workforce, digital resources, the estate, and other physical assets

81 In this section of the report, we provide our high-level views on the Trust's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff wellbeing (please note we will be undertaking a separate review of the organisation's workforce planning arrangements);
- arrangements for managing its digital resources; and
- arrangements for managing its estate and other physical assets.

82 We found **that the Trust has clear plans in place to support staff well-being, harness the benefits of digital, and improve its estate. However,**

[5] We issued a qualified regularity opinion to all Health Boards and the Velindre University NHS Trust due to clinicians' pension tax liabilities.

arrangements for monitoring and reporting on their outcomes require strengthening, particularly in relation to staff well-being and digital.

Supporting staff wellbeing

83 We considered the extent to which the Trust has appropriate and effective arrangements in place for supporting staff wellbeing. In examining this, we have looked at whether:

- mechanisms to seek staff views about their wellbeing needs are effective, and appropriate action is taken to respond to findings; and
- actions to support and improve staff wellbeing are actively monitored by the Board, including actions taken in response to our report on how NHS bodies supported staff wellbeing during the COVID-19 pandemic[6].

84 We found that **the Trust continues to prioritise staff well-being, but its arrangements for measuring and reporting on the effectiveness of well-being interventions require strengthening.**

85 The Trust continues to prioritise staff well-being in line with its People Strategy and 2022-25 IMTP. The Trust recognises that having healthy, valued, and engaged staff will result in improved retention, increased innovation, lower levels of sickness absence, and have a positive effect on patient and donor experience. The People Strategy outlines key deliverables to achieve this[7].

86 In September 2022, Internal Audit completed an advisory review of the effectiveness of staff well-being support and initiatives which found that:

- the Trust captures, monitors, and reports a range of staff related activity to assess well-being levels; and
- intervention effectiveness measurement is not prominent in Trust reporting and not sufficiently well-defined to effectively assess the impact on well-being.

Internal Audit recommended that the Trust should consider other interventions to further support improvements in staff well-being, and fully explore and develop the means and measures by which the success or effectiveness of its well-being initiatives will be determined. In our view, this should also include surveying staff directly to better understand how they are feeling and whether the well-being services and initiatives they access are meeting their needs.

[6] Taking care of the carers? How NHS bodies supported staff wellbeing during the COVID-19 pandemic.

[7] People Strategy key deliverables include developing a Health and Well-being Framework; appointing a Clinical Psychologist to support staff; improving staff engagement by developing an Engagement Strategy; and delivering a range of mental, physical, and financial well-being support.

87 In May 2022, the Audit Committee received the Trust's management response to our Taking Care of the Carers report. The Trust reported to the Audit Committee in July 2022 that it had fully addressed all six recommendations.

88 The Board and Quality, Safety, and Performance Committee continue to receive and consider key workforce metrics at every meeting, including staff sickness levels, Performance Appraisal and Development Review (PADR) completion rates, and statutory and mandatory training levels. Until July 2022, the report also included reasons for staff sickness. The latest report (November 2022) showed that the Trust was meeting the statutory and mandatory training target of 85%, its PADR completion rates were improving, but staff sickness, at 6.31%, remained above the organisation's target of 3.54%.

Managing digital resources

89 We considered the extent to which the Trust has appropriate and effective arrangements in place for managing its digital resources. In examining this, we have looked at whether:

- there is a Board approved digital strategy in place which seeks to harness and exploit digital technology to improve the quality, safety, and efficiency of services, as well as to support new models of care and new ways of working; and
- benefits arising from investments in digital technology are actively monitored by the Board.

90 We found that **the Trust has ambitious plans to harness the potential of digital to transform service delivery, but some of its digital plans are not costed or funded and arrangements for monitoring and reporting on the benefits of digital require strengthening**.

91 The Trust has a clear digital vision as set out in its ten-year Digital Strategy, which the Board approved in May 2022. The strategy clearly sets out how digital technology and insight can support the drive to continually improve the quality, safety, experience, and outcomes of services to meet the ambitions described in the Trust's wider ten-year Trust strategy. The Trust also recognises the opportunities that exist to better harness data sources to provide greater insights into population needs and expectations with a view to challenging professional assumptions and support wider service improvement plans.

92 The Trust has fully costed its larger digital projects as part of the 2022-25 IMTP planning process. The Corporate Risk Register presented to the Audit Committee in July 2022 reflects the risk that the digital services team are unable to support agreed divisional/Trust strategic and operational digital objectives as a result of limited capacity within the team. It details a series of mitigating actions, including developing a digital financial strategy, regularly reviewing the digital work plan to ensure the Trust aligns digital 'delivery' to its overall strategic priorities, and using agile principles to prioritise digital services resources.

93 There is good reporting from the Digital Services Operational Group report to the Quality, Safety, and Performance Committee on key digital projects and programmes and significant IT business continuity incidents. Whilst the reports provide a good overview of progress, they do not provide an assessment of what difference digital projects and programmes are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. As a result, the Quality, Safety, and Performance Committee is unable to actively monitor and scrutinise the benefits arising from the Trust's investment in digital programmes and projects and provide full assurance to the Board. The Trust, therefore, should consider how best to monitor and report the benefits of its digital investment to demonstrate to the Board the extent that it has achieved its intended impacts and outcomes (**Recommendation 5**).

Managing the estate and other physical assets

94 We considered the extent to which the Trust has appropriate and effective arrangements in place for managing its estate and other physical assets. In examining this, we have looked at whether:

- there are Board-approved strategies and plans in place for managing the organisation's estates and its wider physical assets;
- there are appropriate arrangements in place for the Board to review, scrutinise, challenge, and approve significant capital projects and programmes; and
- there are appropriate arrangements in place for the Board to maintain appropriate oversight of the condition of the estate and other physical assets.

95 We found that **the Trust has a clear vision for its estates and good arrangements for ensuring Board-level oversight and scrutiny of key estates related risks and matters.**

96 The Trust has a clear vision for estate as set out in its Estates and Sustainability Strategies, which the Board approved in May 2022. The Estates Strategy has a clear focus on having a safe and high-quality estate which provides a great experience for staff, patients, donors. The Sustainability Strategy has a clear focus on maximising the Trust's contribution to its communities and mitigating its environmental impact on the planet. The Sustainability Strategy includes a decarbonisation plan to support delivery of the Trust's ambitions to be Carbon Net Zero. The key deliverables are set out in the 2022-25 IMTP.

97 The Trust has an established process for prioritising competing capital cases, both in terms of submissions to the all-Wales Capital Fund and the Trust's Discretionary Capital Programme. The 2022-25 IMTP clearly sets out the Trust's capital schemes and sources of funding. The Trust's Board routinely receives business cases relating to significant capital projects and programmes for review, scrutiny, and approval.

98 The Trust has effective arrangements in place for the Board and its committees to maintain appropriate oversight of matters relating to the estate in terms of health and safety, fire safety, and environmental and statutory compliance. The Trust's Estates Assurance Group reports regularly to the Quality, Safety, and Performance Committee. The reports helpfully draw attention to the key matters requiring consideration by the committee. The Quality, Safety, and Performance Committee receive the Annual Estates Report and the Annual Health and Safety Report and consider overall progress. The Trust's Transforming Cancer Services[8] Scrutiny Sub-Committee maintains effective oversight of all estates and capital matters, risks, and issues associated with the Transforming Cancer Services programme, including those associated with the development of the new Velindre Cancer Centre.

99 The Trust has an aging estate to manage in terms of the current Velindre Cancer Centre and there is a programme of work to upgrade Welsh Blood Service facilities. As at 2020-21, the Trust's risk adjusted cost for addressing all backlog maintenance is £1,875,521. Corporate risks relating to capital assets are scrutinised by the Quality, Safety, and Performance Committee. The Trust's challenge in the short- and medium-term will be achieving an appropriate balance between maintaining the current estate whilst investing in the future estate. The Trust is aware of this challenge and recognises that it will involve difficult investment decisions.

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

Appendix 1

Audit approach

Exhibit 5 sets out the approach we adopted for delivering our structured assessment work at the Trust.

Exhibit 5: audit approach

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following Committees: • Quality, Safety, and Performance Committee; • Strategic Development Committee; and • Audit Committee.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • Key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interests, and Registers of Gifts and Hospitality; • Key organisational strategies and plans, including the IMTP; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • Relevant policies and procedures; and • Reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following Senior Officers and Independent Members: • Chair of the Board; • Director of Strategic Transformation, Planning and Digital and (at the time of the review) Interim Chief Executive; • Director of Corporate Governance and Chief of Staff; and • Executive Director of Finance.

Archwilio Cymru
Audit Wales

Organisational response

Report title: Structured Assessment 2022 – Velindre University NHS Trust
Completion date: March 2023
Document reference: 3296A2022

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
R1	**Improving administrative governance arrangements** We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing: • missing committee meeting papers. • the Register for Gifts, Hospitality and Sponsorship and the Declarations of Interest Register; and • 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.	Yes	Yes	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. 10-year strategy: An engagement and communications plan has been developed to the support the launch of the Trust 10-year strategy in May 2023. This will include publishing the strategy on the Trust website.	22nd March 2023 31st May 2023	Operational Lead: Corporate Governance Manager Executive Lead: Lauren Fear – Director of Corporate Governance and Chief of Staff Carl James, Executive Director of Strategic Transformation, Planning and Digital

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
R2	**Reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies** The Quality, Safety, and 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.	Yes	Yes	The Quality & Safety Extract of the Trust wide Legislative & Regulatory Compliance Register will be received at each meeting of the QSP Committee – together with the associated Improvement Plan using the 7 levels of assurance template. Note: the Trust wide Legislative & Regulatory Compliance Register is already established and received in full by the Trust Audit Committee.	March 2023	Operational Lead: Head of Quality & Safety & Head of Corporate Governance Executive Lead: Nicola Williams, Executive Director Nursing, AHP & Health Science
R3	**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	Yes	Yes	The Trust IMTP 2023-2026 sets out a range of priorities which have specific objectives related to their delivery which are timebound. Further work will be undertaken to: (i). improve the SMART elements of the objectives	30th March 2023	Executive Lead: Carl James, Executive Director of Strategic Transformation, Planning and Digital

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
	IMTPs, including what success would look like.			(ii). align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase 2)	December 2023	
R4	**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.	Yes	Yes	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 updates 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	31st May 2023	Executive Lead: Carl James, Executive Director of Strategic Transformation, Planning and Digital

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
R5	**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 assessment of what difference they are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.	Yes	Yes	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 (ii). improving the clarity of benefits in projects/business cases on a case-by-case basis (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	31st May 2023 Not time bound – as related to each business case February 2024	Executive Lead: Carl James, Executive Director of Strategic Transformation, Planning and Digital

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

AUDIT COMMITTEE

2022/23 INTERNAL AUDIT PROGRESS UPDATE

DATE OF MEETING	23/04/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

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

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Audit Committee is asked to:

- **RECEIVE** the reports from Internal Audit, note their content and request further action, information or assurances if required; and

- **NOTE** the action being taken and further action required regarding:

    - reported performance against Key Performance Indicator 4 (management responses); and

    - delays encountered on the new Velindre Cancer Centre Integrated Audit & Assurance Plan for the 2022/23 remaining audits and planning for the IAAP going forward.

2022/23 Internal Audit Progress and KPI Dashboard

Velindre University NHS Trust

17th April 2023

Contents

Executive Summary

Alert / Escalate

Timeliness of Management Responses

- KPI 4 (Management Response) is RAG rated red, reported at 47%.
- This has deteriorated from the January 2023 reported position (50%).
- One further draft report has missed the management response deadline. Inclusion of this report would reduce KPI 4 to 44%.

Improvement action being taken by Audit & Assurance Services:

- Monthly progress reporting to the EMB Run meeting.
- Trialing a more collaborative approach to responses using Teams.
- Developing a dashboard to provide EMB with up-to-date information on audit progress, including management response deadlines.

Action required of Trust management:

- Greater awareness of the management response deadline (15 working days / 3 weeks from the issue of the draft report).
- Provision of timely comments and management responses on draft reports.

2022/23 Integrated Audit & Assurance Plan (IAAP)

- We are experiencing delays on the three remaining nVCC IAAP audits for 2022/23.
- We understand this to be due to Trust staff involvement in the nVCC Final Business Case (FBC).
- The delays may mean we are unable to include these audits in the 2022/23 Head of Internal Audit Annual Opinion.
- This has also impacted our planning for the 2023/24 IAAP and the IAAP programme to be included in the nVCC FBC.

Action required of Trust management:

- Engagement with our Specialist Services Unit (Capital & Estates Specialists) team to progress and complete IAAP fieldwork and 2023/24 / FBC programme planning.

Advise

2023/24 Internal Audit planning

- We have completed our 2023/24 annual planning.
- The proposed annual plan will be presented at the April 2023 Audit Committee for approval.

Audit Committee reporting

We agreed with the Audit Committee Chair that, unless otherwise required, substantial and reasonable assurance reports that do not contain high priority recommendations will be included on the consent agenda.

Assure

Progress

Progress is being made on the 2022/23 Internal Audit Plan. Of the 21 planned reviews:

- 14 reports have been issued as final;
- 2 reports have been issued in draft and are awaiting management responses; and
- 3 audits are in progress.

KPIs

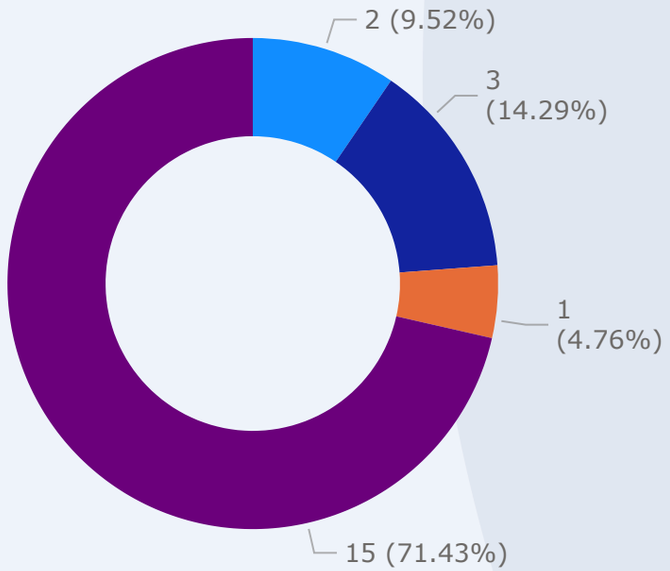
Except for KPI 4 (see alert section), all KPIs are rated green.

Other activities

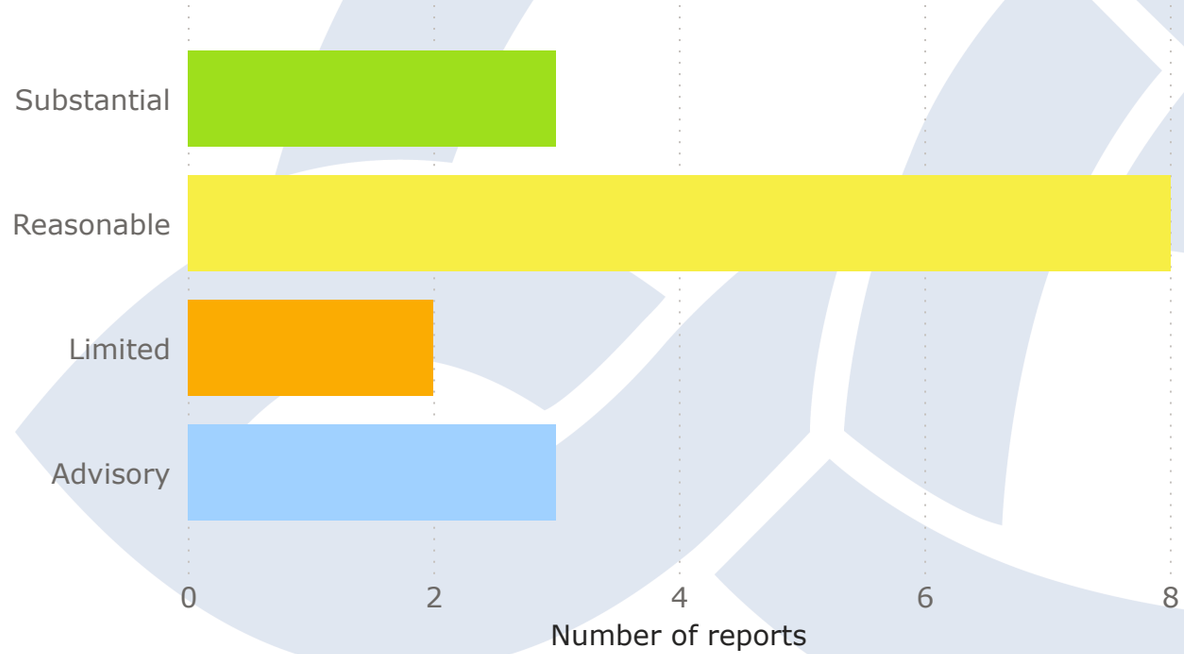
- Regular meetings with the Director of Finance and Director of Corporate Governance;
- Planning meetings with various Executive Directors;
- Attendance at Trust Board and Committee meetings;
- Attendance at the 18th April 2023 Board Development Session to support the 2022/23 Integrated Annual Board Effectiveness Assessment process.

Overview

2022/23 Audit Status



2022/23 Reports by Assurance Rating (Draft & Final)

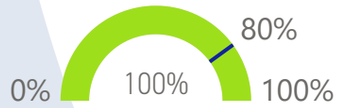


Key Performance Indicators

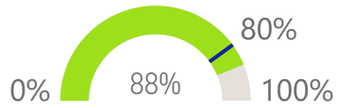
KPI1 - Timely delivery of Annual Plan & Report

Yes

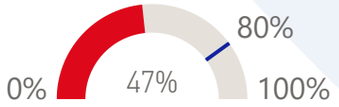
KPI2 - Report delivery in line with plan



KPI3 - Timely issue of draft report



KPI4 - Timely management response



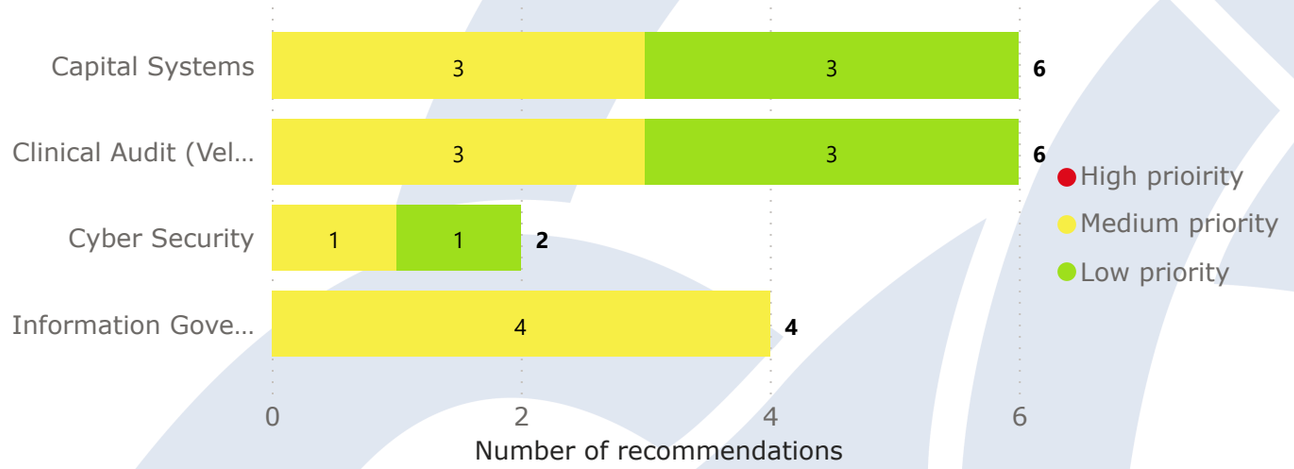
KPI5 - Timely finalisation of report

KPI6 - Delivery to planned Audit Committee

Yes

Final Reports Issued Since Previous Meeting

Audit Committee Agenda	Assurance
Consent	
Capital Systems	Reasonable
Clinical Audit (Velindre Cancer Centre)	Reasonable
Information Governance	Reasonable
Private	
Cyber Security	Substantial



Final **reports** are included on Audit Committee agendas as follows:

Main agenda:
- All limited and no assurance reports
- Any substantial or reasonable assurance reports with high priority recommendations
- Other assurance reports by Audit Committee Chair decision or Independent Member request

Consent agenda:
- Substantial and reasonable assurance reports containing only medium and / or low priority recommendations

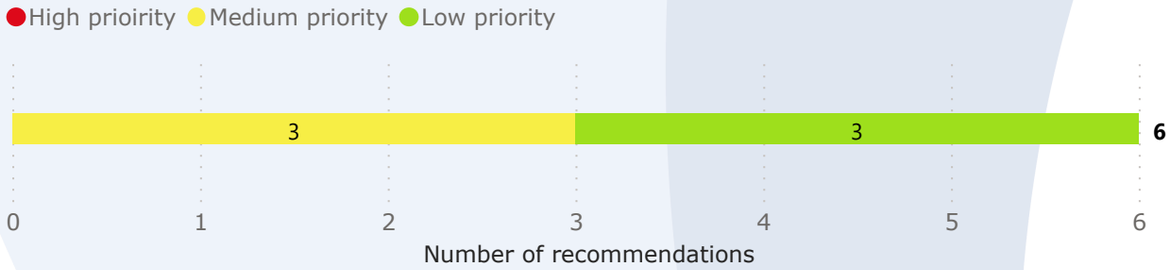
Private agenda:
- Any report considered to contain sensitive commercial, patient or personal information

Final **advisory reports** will be included on the appropriate agenda on a case by case basis.

Reports included on the **public consent agenda** are summarised on the following pages.

Overview of Final Reports on Consent Agenda

Capital Systems - reasonable assurance



Purpose: To evaluate the processes and procedures operating to support the prioritisation and allocation of the Trust's discretionary capital funds.

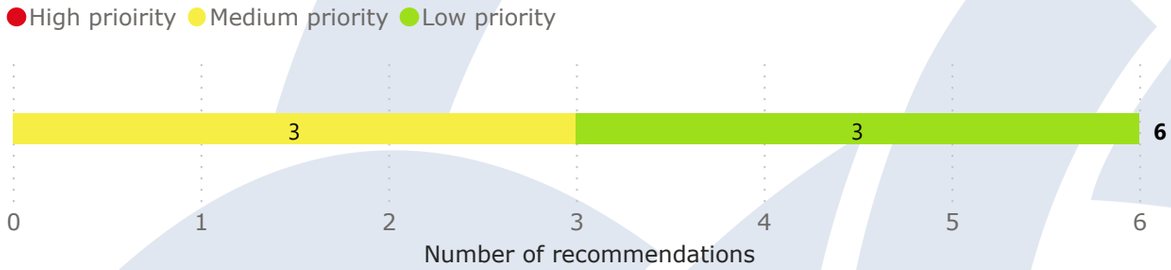
Overview of findings:

- A robust procedural framework was in place to direct the prioritisation and approval of discretionary capital, with compliance generally evident at Division level
- Minor points of enhancement have been recommended to ensure this framework remains up to date and supports consistency across Divisions and departments.
- Minutes of the Capital Planning Group meeting at which the 22/23 discretionary capital programme was endorsed lacked the necessary detail to provide a clear audit trail of the processes applied.
- Forthcoming changes to the capital governance structure will strengthen the governance arrangements operating in this area.

Key matters requiring attention:

- Re-instatement or review of the VCC Business Planning Group.
- The appropriate minuting of Capital Planning Group meetings to provide a clear audit trail of decision making.
- Where possible, the formulation and approval of the annual discretionary capital programme in a more timely manner.

Clinical Audit - reasonable assurance



Purpose: To provide assurance that the Trust has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services

Overview of findings:

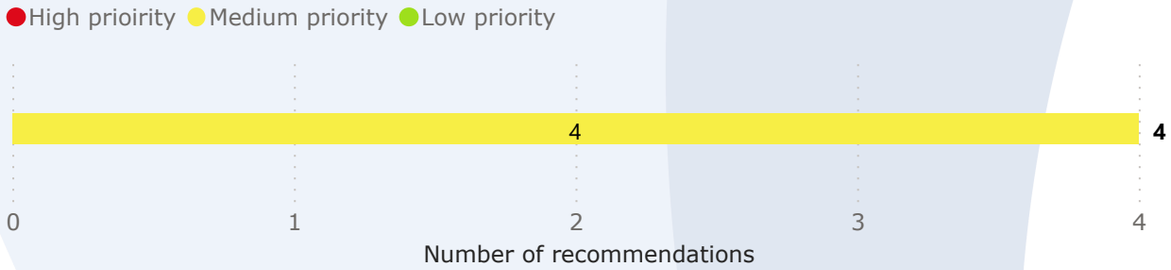
- The Trust has an approved clinical audit approach. The Trust-wide Clinical Audit Plan incorporates national clinical audits and the local clinical audit programmes for each division.
- Mechanisms are in place within Velindre Cancer Centre to monitor progress against its local Clinical Audit Programme, and implementation of actions, and to disseminate learning.
- We identified three medium priority recommendations to enhance these mechanisms.

Key matters requiring attention:

- None noted

Overview of Final Reports on Consent Agenda (continued)

Information Governance - reasonable assurance



Purpose: To assess the effectiveness of the Trust's IG processes and provide assurance that principles and practices are followed and working as intended.

Overview of findings:

- The Trust has an active IG function which is engaged in the ongoing development and enhancement of the Trust's IG activities.
- The audit identified areas for improvement, most of which are covered by the Trust's IG development plan, which is reported quarterly to the Executive Management Board.

Key matters requiring attention:

- The need to improve the Information Asset register.
- Development of a Records Management Strategy and Standard Operating Procedure.
- To consider whether the level of IG resource is sufficient and how mandatory IG training update levels can be improved.

Reports by Assurance Rating

Substantial Assurance Reports

Audit	Status	High	Medium	Low
Cyber Security	Final report	0	1	1
Digital Health Record - Implementation	Final report	0	0	0
Research & Development	Final report	0	0	0

Reasonable Assurance Reports

Audit	Status	High	Medium	Low
Capital Systems	Final report	0	3	3
Clinical Audit (Velindre Cancer Centre)	Final report	0	3	3
Divisional Review - Managing Attendance at Work	Final report	1	3	4
Finance & Service Sustainability	Final report	0	4	4
Information Governance	Final report	0	4	0
nVCC Enabling Works (deferred from 2021/22)	Final report	0	2	4
Patient & Donor Experience	Final report	0	3	0
Performance Management F/w	Final report	0	1	8

Limited Assurance Reports

Reports	Status	High	Medium	Low
nVCC MIM Contract Management	Final report	1	0	0
nVCC Enabling Works (2022/23)	Draft report	0	10	4

No Assurance Reports

No 'no assurance' reports have been issued

Advisory Reviews

Audit	Status
Estates Assurance - Decarbonisation	Final report
nVCC EW Security Contract	Final report
Staff Wellbeing (Advisory)	Final report

2022/23 Internal Audit Plan Progress and KPI Performance by Audit

Audit	Status	Assurance rating	Planned Audit Committee	Actual Audit Committee	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6
Capital Systems	Final report	Reasonable	25/04/23	25/04/23	✓	✓	✓	✓	✓
Clinical Audit (Velindre Cancer Centre)	Final report	Reasonable	12/01/23	25/04/23	✓	✗	✗	✓	✗
Cyber Security	Final report	Substantial	25/04/23	25/04/23	✓	✗	✗	✓	✓
Digital Health Record - Implementation	Final report	Substantial	12/01/23	12/01/23	✓	✓	✗	✓	✓
Divisional Review - Managing Attendance at Work	Final report	Reasonable	04/10/22	12/01/23	✓	✓	✗	✓	✓
Estates Assurance - Decarbonisation	Final report	Advisory	12/01/23	12/01/23	✓	✓	✗	✓	✓
Finance & Service Sustainability	Final report	Reasonable	04/10/22	04/10/22	✓	✓	✓	✓	✓
Information Governance	Final report	Reasonable	25/04/23	25/04/23	✓	✓	✓	✓	✓
nVCC Enabling Works (deferred from 2021/22)	Final report	Reasonable	04/10/22	04/10/22	✓	✓	✗	✓	✓
nVCC EW Security Contract	Final report	Advisory	19/07/22	19/07/22	✓	✓	✗	✓	✓
nVCC MIM Contract Management	Final report	Limited	12/01/23	12/01/23	✓	✓	✗	✓	✓
Patient & Donor Experience	Final report	Reasonable	12/01/23	12/01/23	✓	✓	✓	✓	✓
Performance Management F/w	Final report	Reasonable	25/04/23	12/01/23	✓	✓	✓	✓	✓
Research & Development	Final report	Substantial	04/10/22	04/10/22	✓	✓	✓	✓	✓
Staff Wellbeing (Advisory)	Final report	Advisory	04/10/22	04/10/22	✓	✓	✓	✓	✓
nVCC Enabling Works (2022/23)	Draft report	Limited	25/04/23		✓	✓			
Follow Up	Fieldwork		26/07/23						
nVCC MIM Planning	Fieldwork		26/07/23						
Trust Priorities	Fieldwork		26/07/23						
nVCC MIM Design & Change Management	Planning		26/07/23						
nVCC MIM Procurement & Approvals	Planning		26/07/23						

Appendix A: Reconciliation of 2022/23 Internal Audit Plan

Total audits in approved 2022/23 plan	22
Less:	
• Audits deferred *(Quality & Safety Framework - note 1)*	-1
• Audits cancelled *(nVCC Validation of Management Actions - note 2)*	-1
Add:	
• Audits added to replace deferred *(Information Governance)*	1
Total audits to be delivered	**21**

Notes

1. Quality & Safety Framework: we agreed to defer the Quality & Safety Framework audit to early in the 2023/24 plan due to the overlap with the Audit Wales Quality Governance report. The audit was replaced with an audit of Information Governance. This change to the 2022/23 annual plan was approved (out of committee) by the Audit Committee in December 2022 and ratified in the January 2023 Audit Committee meeting.

2. nVCC Validation of Management Actions: this audit will not take place due to follow-up on previous recommendations being undertaken as part of the 2022/23 Contract Management audit within the nVCC Integrated Audit & Assurance Plan rather than as a separate report. Audit Committee approval was not required for this change.

Appendix B: Assurance Opinion, Action Plan Risk Rating and KPI Definitions

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:

Audit Assurance Rating	Definition	Impact on residual risk exposure
Substantial assurance	Few latters require attention and are compliance or advisory in nature	Low
Reasonable assurance	Some matters require management attention in control design or compliance.	Low to moderate
Limited assurance	More significant matters require management attention.	Moderate
No assurance	Action is required to address the whole control framework in this area.	High
Assurance not applicable / Advisory review	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.	N/a

Prioritisation of Recommendations

Priority Level	Definition	Potenital impact	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.

KPI definitions

KPI	KPI Definition	Target
KPI 1	Timely approval of Annual Plan	Apr-22
KPI 2	Review delivered (draft report issued) in line with plan	80%
KPI 3	Report turnaround: time from fieldwork completion to draft reporting (10 days)	80%
KPI 4	Report turnaround: time taken for management response to draft report (15 days)	80%
KPI 5	Report turnaround: time from management response to issue of final report (10 days)	80%
KPI 6	Reports delivered to Audit Committee in line with plan	Y/N

AUDIT COMMITTEE

2023/24 INTERNAL AUDIT PLAN

DATE OF MEETING	25/04/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB Shape	20/02/23	EMB feedback provided, initial proposed plan updated
EMB Run	03/04/23	Endorsed for Audit Committee Approval

ACRONYMS / DEFINITIONS	
We	Audit & Assurance Services
TAF	Trust Assurance Framework

ACRONYMS / DEFINITIONS	
TRR	Trust Risk Register
EMB	Executive Management Board
IMs	Independent Members
TCS	Transforming Cancer Services
IRS	Integrated Radiotherapy Solution
IAAP	Integrated Audit & Assurance Plan
nVCC	New Velindre Cancer Centre
FBC	Final Business Case

APPENDICIES	
1	2023/24 Draft Internal Audit Plan
2	Internal Audit Assurance over Strategic Risks (TAF)
3	Internal Audit Assurance over Trust Priorities

1. SITUATION/BACKGROUND

2023/24 annual planning

We have completed our planning for the 2023/24 internal audit annual plan. We have:

- met with the Trust's Directors and Independent members;
- reviewed key documents, including the TAF, TRR and the Trust strategies and priorities;
- considered of previous reviews we have done and their outcomes;
- met with Audit Wales to understand its intended reviews to avoid duplication;
- considered of areas for potential all Wales reviews; and
- received EMB endorsement for Audit Committee approval.

Based on this, we have developed our draft 2023/24 Internal Audit Plan and Internal Audit Charter to be approved by the Audit Committee.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The draft 2023/24 annual plan is summarised below. The full 2023/24 draft plan, including proposed outline scopes and our Internal Audit Charter, is detailed in Appendix 1 **for approval by the Audit Committee**.

2023/24 Draft Internal Audit Annual Plan

Planned review		Link to (note i):		
		TAF	TRR	Trust priorities
Financial Governance & Management				
1	Financial & Service Sustainability	08	-	26 (poss)
Information Governance & Security				
2	Digital Strategy & Transformation Programme	07 / 09	2769, 2774, 2775, 2776, 2779, 2689	15
3	TCS Digital Project (placeholder – see note ii)	05 / 07	-	3
Workforce Management				
4	Recruitment & Retention (advisory review)	01 / 03 / 04	2187, 2612, 2515. 2579	-
5	Education Strategy	04	-	-
Operational Service & Functional Management				
6	Private Patients	-	-	34
7	Business Continuity	-	-	-
Corporate Governance, Risk Management & Regulatory Compliance				
8	Decarbonisation (All Wales)	09 / 10	-	18
9	Follow-up of prior year recommendations	10	-	25
Strategic Planning, Performance Management & Reporting				
10	IRS Implementation (placeholder – see note ii)	05 / 07 / 09	-	30
Quality & Safety				
11	Medicines Management	-	-	-
12	Trust Quality & Safety Framework	09 / 10	-	8, 11, 13, 17, 19

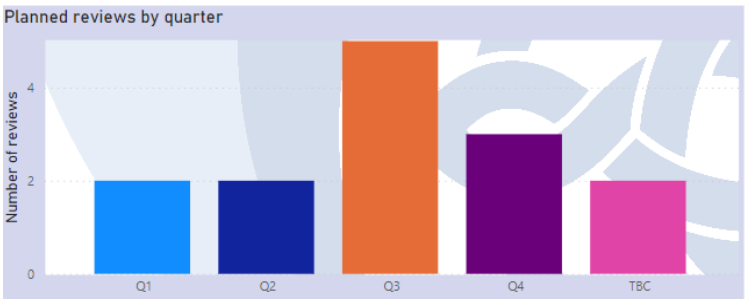
Planned review		Link to (note i):		
		TAF	TRR	Trust priorities
Capital & Estates Management				
13	Capital Assurance – Systems / Infrastructure	-	-	-
14	Estates Assurance – Estates Condition (All Wales)	-	-	-
Integrated Audit & Assurance Plans (see note iii)				
-	nVCC	05 08 / 09 10	2714, 2800	2
-	Enabling Works			

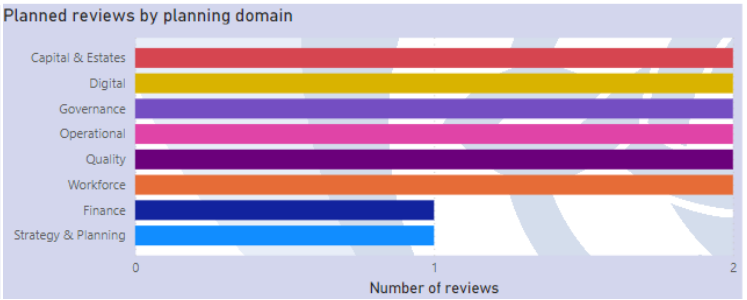
i. Link to TAF and Trust Priorities: to give the Trust a clear overview of the assurance we provide against key matters and to support engagement in the 2023/24 internal audit planning process, we have mapped the reviews we have previously undertaken (from 2018/19 to 2022/23) and our proposed future reviews to the Trust Assurance Framework (detailed further in Appendix 2) and Trust Priorities (detailed further in Appendix 3). EMB should consider this mapping in conjunction with assurances the Trust receives from elsewhere, for example, Audit Wales, Healthcare Inspectorate Wales, Medicines and Healthcare products Regulatory Agency, etc.

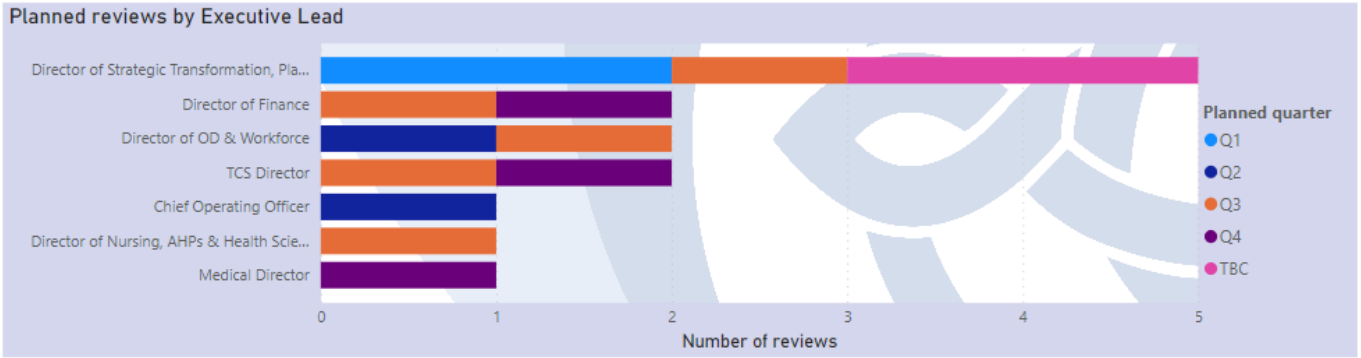
ii. TCS Digital Project and IRS Implementation audits: these reviews may be undertaken as part of the nVCC IAAP and/or as part of the Capital Assurance audit (ref 13), which will be confirmed upon inclusion of the IAAP in the nVCC FBC. If included in the IAAP / Capital Assurance audit, replacement audits will be identified using the 'other areas covered in 2023/24 planning' identified below as a starting point.

iii. Integrated Assurance & Audit Plans: these are subject to a separate annual planning process and annual plans. The IAAPs are aligned to the delivery of major capital projects to provide assurance throughout the duration of the project. The 2023/24 IAAPs will be presented to EMB and the Audit Committee once agreed. They are reported in our monthly progress updates to EMB (and similarly to each Audit Committee) and form part of our Head of Internal Audit Annual Opinion.

The graphs below analyse the 2023/24 annual plan by quarter, by Executive Lead and by planning domain:







Other areas considered in 2023/24 planning

The below table sets out areas we identified for potential inclusion the 2023/24 Internal Audit Plan. Based on our considerations outlined in the introduction section, these areas will not be covered in the 2023/24 plan. We have included them here for completeness. These will be considered as priority areas for the 2024/25 plan and could be used as options for replacement reviews should any planned reviews be deferred or cancelled.

Workforce	Digital
Culture & Values (TAF 04, priority 28) People Strategy (TAF 03 / 04 / 09) Equality Diversity & Inclusion (TAF 04) Job Planning (TAF 03)	Records Management Service Management BI Infrastructure (advisory review) (TAF07)
Governance	**Quality Governance**
Communication & Engagement (TAF 02 / 04, priority 32) Charity Governance Freedom of Information	Falls Management (VCC) Patient Engagement Strategy (VCC)
Strategy & Planning	**Operational**
Post-Covid Recovery	Health & Safety WBS Wrexham Site Management

During the 2023/24 annual planning process, we also identified several areas for consideration beyond 2023/24 and have set these out below for information. Assurance to the Trust on these areas may already be planned from other sources.

From planning meetings with Directors and IMs	From review of Trust Priorities – long list (recently audited)
Pharmaceutical Waste Management Performance Management Framework (Priority 34) Risk Management – roll out of new Framework (part of Priority 25) Welsh Language Standards Digital Health & Care Record (Priority 27)	Staff Wellbeing (advisory) (Priority 1)
From review of Trust Priorities – must and should do reviews	**From review of Trust Priorities – long list (not recently audited)**
Revenue-funded elements* of: • Velindre Futures programme (Priorities 21, 22, 24) • WBS Futures programme (Priorities 4, 38, 39) Radiotherapy Satellite Centre – Trust responsibilities (Priority 10) TCS Outreach Services Project (Priority 29) Ways of Working Programme (Priority 33) Governance, Risk & Assurance Programme (Priority 25) ** For example, service redesign / transformation / modernisation, workforce planning, financial (revenue) planning, etc. Capital-funded elements will be subject to separate IAAPs.*	Research & Development programmes (Priorities 5, 6) BOFT: Clinical & Scientific Arrangements (Priority 7) BOFT: Leadership Development (Priority 12) WBS Futures: • Plasma for Medicines Programme (Priority 14) • Welsh Bone Marrow Donor Registry Programme (Priority 20) VCC Development Programmes: • Acute Oncology Service (Priority 23) • Transforming Access to Medicines Programme (Priority 36) WBS Development Programmes: • HEP B Testing (Priority 31) • Advanced Welsh Medical Genetics (Priority 35)

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Audit Committee is asked to:

- **APPROVE** the draft 2023/24 Internal Audit Plan and Internal Audit Charter; and
- **NOTE** the identified areas for potential internal audit coverage beyond 2023/24 or which could be used to replace 2023/24 reviews should the need arise.

Annual Internal Audit Plan: For Audit Committee Approval

Internal Audit Charter

April 2023

Velindre University NHS Trust

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2023/24 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Trust Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Trust management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2023/24. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by Health Education & Improvement Wales (HEIW), Public Health Wales (PHW), Digital Health and Care Wales (DHCW), NWSSP, Welsh Health Specialised Services Committee (WHCCS) and Emergency Ambulance Services Committee (EASC) on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for HEIW, PHW, DHCW, NWSSP and Cwm Taf Morgannwg UHB (for WHSSC and EASC) but the results, as in previous years, are reported to the relevant organisation and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance, Trust Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Trust Assurance Framework and the Trust Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no/unsatisfactory assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Trust, namely HEIW, PHW, WHSSC, NWSSP, DHCW and EASC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Trust's systems of assurance

The risk based internal audit planning approach integrates with the Trust's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Trust strategies, the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Trust's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Quality, Safety and Performance Committee);
- key strategic and operational risks identified within the Trust Assurance Framework, Trust Risk Register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through HEIW, PHW, WHCCS, NWSSP, DHCW and EASC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Trust Executive and Directors to discuss current areas of risk and related assurance needs.

The draft Plan has been provided to the Trust's Executive Management Board and Audit Committee Chair to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Trust Assurance Framework and Trust Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2023/24

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic and operational risks identified within the Trust Assurance Framework, Trust Risk Register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input is necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that an additional fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Trust, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, project audits will be charged for separately on the basis of the agreed Integrated Audit & Assurance Plans (approved by Welsh Government within their respective business cases). This enables the reduction in the Capital and Estates provisions included within the internal audit plan. The following programme / project audits are scheduled to be progressed during 2023/24:

- New Velindre Cancer Centre: Enabling Works
- New Velindre Cancer Centre: Main Scheme

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2023/24 and:

- approve the Internal Audit Plan for 2023/24;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Simon Cookson

Director of Audit & Assurance and Head of Internal Audit (Velindre University NHS Trust)
Audit and Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2023/2024

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	-	TAF 10	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Chief Executive / Director of Corporate Governance	Q4
Financial & Service Sustainability	01	TAF 08	To review the financial management arrangements in place to ensure sustainability of services, including longer term planning for the Trust's strategies and major change programmes. Specific scope to be determined with management prior to undertaking the work.	Director of Finance	Q3
Digital Strategy & Transformation Programme	02	TAF 07 / 09 TRR 2689, 2769, 2774-6, 2779	To provide assurance over the implementation of the Trust's Digital Strategy and Programme, including considerations around digital literacy and risk to sustainability due to outdated, legacy, obsolete or end-of-life systems.	Director of Strategic Transformation, Planning & Digital	Q1
Transforming Cancer Services (TCS) Digital Project	03	TAF 05 / 07	To provide assurance on the progress of planning and development of digital systems and solutions for the new Velindre Cancer Centre (nVCC) (TCS Project 3).	TCS Project Director	Q4
Recruitment & Retention (advisory)	04	TAF 01 /03 / 04 TRR 2187, 2515, 2579, 2612	To review the effectiveness of the Trust's recruitment and retention activities. The review will focus on whether activities are enhancing recruitment and retention; it will not be an audit of compliance with Trust recruitment processes. *We will work with Audit Wales to ensure our work complements and does not duplicate its Workforce Planning review.*	Director of OD & Workforce	Q2
Education Strategy	05	TAF 04	To provide assurance over the implementation of the Trust's Education Strategy.	Director of OD & Workforce	Q3/4
Private Patients	06	-	To review progress against the actions identified in the independent review of the Trust's Private Patients activity.	Chief Operating Officer	Q2/3

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Business Continuity	07	-	To provide assurance over the Trust's ability to facilitate recovery of key business systems and processes within an agreed timescale through the development of Trust-wide approved plans.	Director of Strategic Transformation, Planning & Performance	Q1
Decarbonisation	08	TAF 09 / 10	To consider progress against the NHS Wales' Decarbonisation Strategic Delivery Plan and the Trust's Decarbonisation Action Plan (demonstrating how the Trust will implement the Strategic Delivery Plan initiatives). Following on from the advisory review delivered in 2022/23, the proposed scope will include governance, strategy progress and implementation.	Director of Strategic Transformation, Planning & Performance	Q3
Follow-up of Prior Year Recommendations	09	TAF 10	To provide assurance that Internal Audit recommendations are implemented in a timely manner and have addressed identified risks, and that the Audit Action Tracker provides complete and accurate updates on progress against Internal Audit recommendations to the Audit Committee.	Director of Finance	Q4
Integrated Radiotherapy Solution (IRS) Implementation	10	TAF 05 / 07 / 09	To provide assurance over the project governance for the IRS Implementation (TCS Project 3a).	TCS Project Director	Q3
Medicines Management	11	-	To provide assurance that operational procedures and practices are compliant with Trust Corporate and National Medicines Management Policies.	Medical Director	Q4
Trust Quality & Safety Framework	12	TAF 06 / 10	To provide assurance that there are cohesive and fully integrated Quality & Safety mechanisms, systems, processes and information that enables the Trust to learn and implement improvement	Director of Nursing, AHPs & Health Scientists	Q3
Capital Assurance	13	-	A provision of time to consider cyclical capital systems areas, examining systems, policies and procedures in place to manage those projects not specifically identified within the audit plan. The scope and sample will be risk assessed and agreed with management prior to undertaking the work.	Director of Strategic Transformation, Planning & Digital	TBC

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Estates Assurance – Estates Condition	14	-	Recognising the high profile afforded to the condition of the NHS Estates and the associated risks, focus during 2023/24 will be targeted to the Estates condition. The areas of review may include, for example, Estates Strategy, scale of the issue, risk exposure, records management, delivery of EFAB funding and progress in addressing key risks.	Director of Strategic Transformation, Planning & Digital	TBC
Integrated Audit & Assurance Plans					
nVCC: Enabling Works	-	TAF 05 / 08 / 09 / 10	Subject to separate audit plans aligned with project development timelines. Plans to be reported to Audit Committee once finalised in line with the Final Business Case.	TCS Project Director	Per IAAPs
nVCC: Main Scheme	-				
NHS Wales national audit work					
Collation of assurances from NHS Wales national audit work	-		To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales, NHS Wales Shared Services Partnership, Digital Health and Care Wales and Emergency Ambulance Services Committee.	Director of Corporate Governance / Director of Finance	Q4

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2023/24
Audit plan 2023/24 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2022/23 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	80%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	80%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Velindre University NHS Trust with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Velindre University NHS Trust. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Velindre University NHS Trust. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;

- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as Health Education and Improvement Wales, Public Health Wales, Welsh Health Specialised Services Committee, Digital Health and Care Wales, NHS Wales Shared Services Partnership and Emergency Ambulance Services Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales requirements of the Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by HEIW, PHW, WHSSC, DHCW, NWSSP and EASC on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Trust Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations;

- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to

fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the

Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
April 2023

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
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Appendix 2: Internal Audit Assurance over Strategic Risks (TAF)

TAF ref	Risk subject	Assurance from			
		Previous audits *Audits undertaken from 2018/19 - 2022/23 (to Feb-23)*	Future planned audits *2022/23 remaining audits and 2023/24 must and should do audits*	Future potential audits *2023/24 choice audits and post 2023/24 must and should do audits*	IAAPs
1	Demand & Capacity		23/24 Recruitment & Retention (must do)		
2	Partnership Working / Strategic Engagement			23/24 Communication & Engagement (choice)	Yes (must do)
3	Workforce Planning	20/21 Workforce Planning In-year Follow Up (reasonable)	23/24 Recruitment & Retention (must do)	23/24 People Strategy (choice)	
		20/21 Workforce Planning (limited)		23/24 Job Planning (choice)	
4	Organisational Culture	22/23 Staff Wellbeing (advisory)	23/24 Recruitment & Retention (must do)	23/24 Culture & Values (choice)	
				23/24 People Strategy (choice)	
				23/24 Equality, Diversity & Inclusion (choice)	
				23/24 Education Strategy (choice)	
				23/24 Communication & Engagement (choice)	
5	Organisational Change / Strategic Execution Risk	21/22 WBFGA (advisory)	22/23 Trust Priorities (planning stage)	Post 23/24 Outreach Services (must do)	Yes (must do)
		18/19 IMTP (substantial)	23/24 TCS Digital Project (should do)	Post 23/24 Radiotherapy Satellite Centre (should do)	
			23/24 IRS Implementation (should do)	Post 23/24 SACT Service Transformation (should do)	
				Post 23/24 Outpatient Transformation Programme (should do)	
				Post 23/24 VF Service Delivery & Transition (should do)	
				Post 23/24 Collections Modernisation Programme (should do)	
6	Quality & Safety	22/23 Patient & Donor Experience (reasonable)	23/24 Quality & Safety Framework (must do)	24/25 Implementation of Duties of Quality & Candour (should do)	
		20/21 Health & Care Standards (substantial)			
		19 /20Health & Care Standards (reasonable)			
		18/19 Health & Care Standards (reasonable)			
7	Digital Transformation - failure to embrace new technology	22/23 DHCR - Implementation (substantial)	22/23 Cyber Security (fieldwork stage)	24/24 DHCR (should do)	
		21/22 Use of Digital Technology - Fit for the Future (advisory)	22/23 Information Governance (draft report stage)	23/24 BI Infrastructure (advisory) (choice)	
		21/22 DHCR (Canisc replacement) - Project Management (reasonable)	23/24 Digital Strategy & Transformation Programme (should do)		
		18/19 Cyber Security (reasonable)	23/24 TCS Digital Project (should do)		
		18/19 GDPR (reasonable)	23/24 IRS Implementation (should do)		
8	Trust Financial Investment Risk	22/23 Financial & Service Sustainability: Budget Control & Savings Plans (reasonable)	22/23 Trust Priorities (planning stage)	Post 23/24 Financial & Service Sustainability: scope TBC (must do)	Yes (must do)
		20/21 New Contracting Model (substantial)	23/24 Financial & Service Sustainability: scope TBC (must do)		
9	Future Direction of Travel	21/22 WBFGA (advisory	22/23 Trust Priorities (planning stage)	23/24 People Strategy (choice)	Yes (must do)
		18/19 IMTP (substantial)	23/24 Decarbonisation (must do)		
			23/24 Digital Strategy & Transformation Programme (should do)		
			23/24 IRS Implementation (should do)		
10	Governance	21/22 Board Committee Effectiveness (reasonable)	22/23 Trust Priorities (planning stage)	Post 23/24 Governance, Risk & Assurance Programme (must do)	Yes (must do)
		21/22 Trust Assurance Framework (reasonable)	22/23 Follow Up (planning stage)	Post 23/24 Ways of Working (should do)	
		22/23 Estates Assurance - Decarbonisation (advisory)	23/24 Decarbonisation (must do)		
		21/22 Follow Up (reasonable)	23/24 Quality & Safety Framework (must do)		
		20/21 Covid-19 Governance Arrangements (advisory)			
-	Cross-cutting audits (cross more than 2-3 strategic risks)	22/23 Performance Management Framework (reasonable)	22/23 Trust Priorities (planning stage)	24/24 Performance Management (should do)	
		21/22 Trust Assurance Framework incorporating Trust Risk Register (reasonable)	22/23 Follow Up (planning stage)		
		21/22 Follow Up (reasonable)			
		21/22 Divisional Risk Management (reasonable)			
		18/19 Performance Reporting (substantial)			
		18/19 Risk Management (reasonable)			

Appendix 3: Internal Audit Assurance over Trust Priorities

Ref	Programme of Work	Theme	Internal Audit assurance timing status	Previous audit year	Previous assurance	Planned future audit year	Covered by an IAAP	2023/24 audits: Must / Shoud / Choose	Post 23/24: Must / Shoud / Long list	Comments
1	Staff Wellbeing Programme	Workforce	Previously audited	2022/23	Advisory	Post 2023/24	N/a	N/a	Long list	
16	Workforce Redesign	Workforce	Previously audited	2020/21	Reasonable	2023 AW Workforce Planning	N/a	N/a	TBC	Full scope audit in 2019/20 (limited assurance), follow-up audit undertaken in 2020/21 (reasonable assurance). Inclusion in future years depended on 2023 AW review outcome.
2	Enabling Works (Project 1) & nVCC (Project 2)	TCS	Previously audited and future audits planned	2022/23	Various	Ongoing IAAP	Yes - current	M	M	
27	Digital Health & Care Record	IM&T	Previously audited and future audits planned	2022/23	Substantial	2024/25	N/a	N/a	S	Our previous audits covered the DHCR project management (reasonable, 2021/22) and implementation (substantial, 2022/23). We plan to revisit DHCR in 2024/25 to consider the design and embedding of the system.
34	Performance Management	BOFT	Previously audited and future audits planned	2022/23	Reasonable	2024/25	N/a	N/a	S	Our 2022/23 review considered the project management of phase 1 and the design of the new PMF template. We will revisit the PMF in 2024/25 to consider the final phases and how the PMF has been embedded and used in practice.
15	Digital Programme	IM&T	Previously audited and future audits planned	2021/22	Advisory	2023/24	N/a	S	Long list	
18	Implementation of Sustainability Enabling Strategy	Sustainability	Previously audited and future audits planned	2021/22	Advisory	2023/24	N/a	M	M	The 2023/24 audit will focus on decarbonisation, specifically the governance arrangements over the delivery of the Trust's decarbonisation plan.
25	Governance, Risk & Assurance	BOFT	Previously audited and future audits planned	2022/23	Reasonable	Post 2023/24	N/a	In follow-up	M	Our previous audits covered the TAF, TRR and Committee Effectiveness during 2021/22, all of which were reasonable assurance. These reports are being followed up in 2022/23.
3	Digital & Equipment (Project 3)	TCS	Future audits planned	No	N/a	2023/24	Possibly within nVCC IAAP	S	S	
4	Talbot Green Infrastructure	WBS Futures	Future audits planned	No	N/a	Future IAAP	Yes - future	N/a	M	
10	Radiotherapy Satellite Centre (Project 4)	TCS	Future audits planned	No	N/a	Post 2023/24	Yes - in ABUHB plan	N/a	S	We will liaise with the ABU Internal Audit team to ensure the Trust receives the required assurances. We will also consider the elements the Trust is responsible for for inclusion in future audit plans.
9	Quality Hub Implementation	Quality & Safety	Future audits planned	No	N/a	2023/24	N/a	M	TBC	To be covered in the 2023/24 Quality & Safety Framework audit. Inclusion in future years depended on 2023/24 audit outcome.
21	SACT Service Transformation	Velindre Futures	Future audits planned	No	N/a	Post 2023/24	Possibly within nVCC IAAP	N/a	S	
11	Quality Framework	BOFT	Future audits planned	No	N/a	2023/24	N/a	M	TBC	Inclusion in future years depended on 2023/24 audit outcome.
22	Outpatient Transformation Programme	Velindre Futures	Future audits planned	No	N/a	Post 2023/24	Possibly within nVCC IAAP	N/a	S	
13	Implementation of Duty of Quality	Quality & Safety	Future audits planned	No	N/a	2023/24	N/a	M	S	To be covered in the 2023/24 Quality & Safety Framework audit.
24	Service Delivery & Transition (Projects 6a/b (VF design/delivery of clinical model) and 6c (Transition))	Velindre Futures	Future audits planned	No	N/a	Post 2023/24	Possibly within nVCC IAAP	N/a	S	
17	Quality Management System	BOFT	Future audits planned	No	N/a	2023/24	N/a	M	TBC	To be covered in the 2023/24 Quality & Safety Framework audit. Inclusion in future years depended on 2023/24 audit outcome.
19	Implementation of Duty of Candour	Quality & Safety	Future audits planned	No	N/a	2023/24	N/a	M	S	To be covered in the 2023/24 Quality & Safety Framework audit.
29	Outreach Services (Project 6)	TCS	Future audits planned	No	N/a	Post 2023/24	N/a	N/a	M	
33	Ways of Working	BOFT	Future audits planned	No	N/a	Post 2023/24	N/a	N/a	S	
38	Laboratory Services Modernisation Programme	WBS Futures	Future audits planned	No	N/a	2024/25	Yes - future	N/a	M	
39	Collections Modernisation Programme	WBS Futures	Future audits planned	No	N/a	Post 2023/24	N/a	N/a	S	
30	IRS Implementation (Project 3a)	TCS	Future audits planned	No	N/a	2023/24	N/a	S	TBC	Dependent on outcom of the 2023/24 audit
37	Private Patients Strategic Development	Non VF Service Development	Future audits planned	No	N/a	2023/24	N/a	S	TBC	Dependent on outcom of the 2023/24 audit
8	Implementation of Patient Engagement Strategy	Quality & Safety	Possible 2023/24 audit (choice list)	No	N/a	2023/24 TBC	N/a	C	TBC	Dependent on inclusion in 2023/24 plan
26	Value Based Healthcare	BOFT	Possible 2023/24 audit (choice list)	No	N/a	2023/24 TBC	N/a	C	TBC	Considering for potential inclusion in Finance & Service Sustainability audit scope
28	Value & Culture	BOFT	Possible 2023/24 audit (choice list)	No	N/a	2023/24 TBC	N/a	C	TBC	Dependent on inclusion in 2023/24 plan
32	Internal Staff Communication & Staff Engagement	BOFT	Possible 2023/24 audit (choice list)	No	N/a	2023/24 TBC	N/a	C	TBC	Dependent on inclusion in 2023/24 plan
5	Delivery of University Status Strategic Pillar	Research & Development	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
6	Research Hub @UHW	Research & Development	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
7	Clinical & Scientific Arrangements	BOFT	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
12	Leadership Development	BOFT	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
14	Plasma for Medicines Programme	WBS Futures	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
20	Welsh Bone Marrow Donor Registry Programme	WBS Futures	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
23	Acute Oncology Service Development (VCC responsibilities for implementation of regional model funded by business cases by 24/25)	Non VF Service Development	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
31	HEP B Testing	Non WBSF Service Development	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
35	Advanced Welsh Medical Genetics (Trust role in Advanced Therapies to be clarified)	Non WBSF Service Development	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	
36	Transforming Access to Medicines Programme (national model with some VCC implementation responsibilities)	Non VF Service Development	Long list for post 2023/24	No	N/a	Post 2023/24	N/a	N/a	Long list	

NHS WALES
Velindre University NHS Trust

Counter Fraud Progress Report
01/01/2023-31/03/2023

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 NHS Trust in relation to the third period of reporting for the year 2022-2023. The report covers the period from 01/01/2023 - 31/03/2023.

The report's format has been adopted in order to update the Audit Committee about counter fraud referrals, investigations, activity and operational issues.

At 31st March 2023, 108 days of Counter Fraud work have been completed against the agreed 110 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year. The days have been used strategically in preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and the creation and planning for renewed infrastructure in relation to the organisation's counter fraud response, staff awareness training, policy review, and, commencement of investigation work in relation to the National Fraud Initiative 22-23 exercise.

This report builds upon the previous counter fraud progress reports submitted at the previous audit committee meetings.

The breakdown of these days is as follows: (P=Period) () = Running Total

TYPE	Days P1	Days P2	Days P3	Days P4
Proactive	15	15 (30)	25 (55)	25 (80)
Reactive	9	6 (15)	0 (15)	13 (28)
TOTAL	24	21 (45)	25 (70)	38 (108)

2. Progress

Staffing

The team has been fully resourced for the duration of Q4.

Activity

Infrastructure/Annual Plan

During this reporting period, work has continued in developing the infrastructure that will allow successful compliance with the Counter Fraud Plan for 2022-2023. In this period the below activity has taken place in relation to this area of work -

a. The maintenance of a comprehensive activity database which is already assisting in maintaining a detailed and accurate record of work undertaken.
b. Review of the Counter Fraud Bribery and Corruption Policy – Velindre NHS Trust have their own Counter Fraud Bribery and Corruption Policy. This has now been amended, updated, approved and published.
c. Maintenance of Counter Fraud digital presence – Fully functional, modern, Counter Fraud Intranet site continues to be developed and improved (Link to the site for reference : Counter Fraud - Home (sharepoint.com))
d. Counter Fraud e-Learning arrangements – the situation with regard to this remains the same as previously reported. (Development of Counter Fraud education page on the All Wales 'Learning @ Wales Platform' is now complete. This awaits the new All Wales eLearning package to be finalised and distributed by the Counter Fraud Service Wales. When complete this will be available to all staff as a, Counter Fraud, education, learning and awareness tool. It will be signposted internally within the organisation and will be available to all staff.)

Fraud Prevention Notices and IBURN notices

(These notices are issued nationally by the NHS Counter Fraud Authority and require action by Local Counter Fraud Teams)

During this reporting period there have been no fraud prevention notices issued by the NHS Counter Fraud Authority. There has been one IBURN notice issued. This related to a serial fraudster who targets public sector organisations. Checks made with ESR, Health Roster, NFI and Trac and assurance can be provided that this person has not had any employment with the organisation. Request made to Trac and ESR to flag this individual for future reference as a prevention measure.

Newsletter

The latest newsletter has been produced and published and can be viewed at the following links;

February 2023 Counter Fraud Newsletter (office.com)

https://sway.office.com/enn0HcqsBH3X25hR?ref=email

or; at the Counter Fraud Team Share Point Pages –

Counter Fraud - Home (sharepoint.com)

Local Alerts/Bulletins

During this reporting period one fraud alert has been issued to Velindre UNHST. This was a prevention alert in relation to thefts of Entonox that were being perpetrated at another NHS health Board in Wales. There have been no reported issues at Velindre UNHST.

Awareness Sessions

During this reporting period a total of six (6) awareness sessions have been delivered. Three (3) relating to Mandate Fraud and three (3) relating to General fraud awareness. All have been delivered remotely on the Microsoft Teams Platform.

Referrals/Enquiries

During this reporting period two (2) referrals have been received. Both were promoted to formal investigation and details provided below.

Investigations

1. Information received that a staff member was stealing Morphine based product from the Velindre Cancer Centre. Full investigation carried out. Employee no longer a member of staff. Liaison with Pharmacy Team made and assurance can be provided that all of the medication identified is accounted for. No offences disclosed. Follow on work identified that processes in place are very robust in regard to storage, recording and issuing of controlled drugs. No further action required. **Case Closed.**
2. Referral received from finance team that 'corporate' credit card had been illegitimately used on a number of occasions. Investigation found that the card and been cloned. Liaison made with the Credit Card Company and losses recovered (£163.98). Card cancelled and new card issued. Report made to Action Fraud. **Case Closed.**

Other

The latest National Fraud Initiative exercise has now gone live and investigation work commenced. There are a total of 714 data matches relevant to the Counter Fraud Team and investigation work will continue into these matches into Q1 and Q2 of the new financial year.

NHS WALES
Velindre University NHS Trust

Annual Counter Fraud Report
01/04/2022 - 31/03/2023

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

TABLE OF CONTENTS

1. INTRODUCTION

This Counter Fraud Annual Report has been written in accordance with Welsh Government Directions on Fraud and Corruption, which requires Local Counter Fraud Specialists (LCFS') to provide a written report at least annually to Velindre University NHS Trust on Counter Fraud work undertaken. All NHS organisations, in compliance to their service conditions of their NHS standard contract, must comply with the NHS Counter Fraud Authority's (NHSCFA's) fraud, bribery and corruption standards for providers.

This annual report will highlight the activities undertaken by the LCFS team, and demonstrate how they have delivered their counter fraud, bribery and corruption activities. Additionally, in compliance to the NHSCFA's standards for providers, this annual report will also document and present the following details,

- Days used to deliver counter fraud, bribery and corruption work
- The cost of counter fraud, bribery and corruption work carried out during the year
- Details of any risk based proactive exercises conducted during the year
- The number of incident reports and cases recorded on the NHSCFA Case management system
- Number and type of sanctions imposed, including recoveries made.

Further to this at Appendix 1 performance figures are provided relating to the activity of the team for this financial year (in future this will include year on year benchmarking figures). The aim of this is to provide relevant outcome based metric data to identify areas of strength and areas of need. This data is then used to inform the work for the coming year.

This report has been complimented throughout the year with detailed progress reports presented to the Audit Committee and additional briefings being presented to the Executive Director of Finance. Following acceptance and approval by the Audit Committee, this Counter Fraud Annual Report will be distributed to the NHS Counter Fraud Service (Wales) and is available to the NHSCFA Quality Assurance and compliance team for review if requested.

The NHSCFA is a Special Health Authority charged with identifying, investigating and preventing fraud within the NHS and the wider health groups. The legislation which created the NHSCFA transferred all functions and powers from NHS Protect to the NHSCFA. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care (DHSC). For more information, the NHSCFA website is www.cfa.nhs.uk. For the purposes of

this report, the term 'fraud' refers to a range of economic crimes, such as fraud, bribery and corruption or any other illegal acts committed by an individual or group to make a financial or professional gain, or to cause an economic loss.

2. SUMMARY OF COMPLIANCE

In January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHSCFA worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales Directors of Finance meeting on 19th February 2021.

The section below highlights how LCFS' has demonstrated compliance towards the recognised standards, with some of the key aspects summarised. The NHS CFA measures compliance as follows: Green – fully compliant; Amber – partially compliant; Red – non-compliant. The self-assessment provided below, is monitored and tested by the NHS Counter Fraud Authority by way of compliance visits to the local team.

(A similar breakdown of the actions undertaken by the LCFS team in direct measurement against the Standard requirements for 2021-2022 will be recorded in the NHS CFA Functional Standard Return. This is due for completion by 31st May 2022. This document will be completed by the Counter Fraud Manager and is required to be submitted to the Director of Finance and the Audit Committee Chair for sign-off prior to submission to the NHS CFA.)

- Accountable Individual and Audit Assurance

  The LCFS' overall governance is held by the Executive Director of Finance. The LCFS' has ensured to notify her of any referrals received and regular updates are provided throughout the investigation process. Additional to this, the LCFS' have extended this exchange of information to ensure that where appropriate, the senior workforce members have been briefed where aspects of a Counter Fraud investigation may overlap with that of a

disciplinary concern. During the year regular updates and meetings have taken place between the LCFS and DoF, Head of Internal Audit, the Counter Fraud Champion and other senior managers where appropriate.

The LCFS is an invited member of the Audit Committee and as such has presented regular progress reports of Counter Fraud work undertaken throughout the year. All quarterly progress reports have been provided to committee in a timely manner in order that they are appraised prior to the meetings. The Counter Fraud Manager has attended as required any Audit Committee pre-meetings with the Independent Members, Internal Audit and Audit Wales. The Annual Plan has now been completed in and awaits approval from Director of Finance and Audit Committee. The Govt. Standard 013; NHS Requirements Functional return has been completed and submitted to the NHS Counter Fraud Authority Compliance Team.

GREEN

- Counter Fraud Bribery and Corruption Strategy / Policy and Response Plan

The organisation has a Counter Fraud, Bribery and Corruption Policy. This has been reviewed, updated and amended to ensure that it is fit for purpose and fully aligned to the NHS CFA strategy. The new amended policy has been approved by Executive Management Board and Audit Committee. The policy will be available to staff via the Intranet and will continue to be promoted during fraud awareness work carried out by the team throughout the year. Further work will be carried out in the year ahead to ascertain if it's possible to make the relevant documents more visible. The LCFS team this year has ensured to align its counter fraud, bribery and corruption work to the recent changes in NHSCFA counter fraud, bribery and corruption requirements.

GREEN

- Risk Assessment

The LCFS' team have, where appropriate continued to effectively work across the service to share expertise and guidance around fraud proofing, risks and vulnerability. Counter Fraud maintain a direct review and input role in relation to policy which aims to strengthen the wider practices to reducing the risk of fraud through poor policy or governance controls. Throughout the year the team has carried out risk profiling work in relation to the organisation. Over one hundred and fifty inherent fraud risks to all NHS Organisations have thus far been identified by the NHS Counter Fraud Authority. These are not all relevant to all organisations. Twenty-Seven (27) Fraud Risks have been identified as being directly relevant to VUNHST. A

report of this Risk Profile has been provided to Audit Committee (February 2023). Work has commenced into carrying out comprehensive fraud risk assessments into these areas. The Organisational Fraud Risk Profile will remain a 'living' document. Further to the inherent risks known, specific risks are also added to the profile as they arise as a result of investigation or external reporting e.g. Thematic Exercise, Fraud Prevention Notice, Local Intelligence Report. (A breakdown of the risk assessments carried out is provided below.) Where local risks have been identified, assessment work has been carried out accordingly.

During the year, work continued to be undertaken in relation to the NHSCFA Thematic Exercise that was delayed due to the Covid Pandemic (Mandate Fraud Risk, Invoice Fraud Risk, Supplier Fraud Risk). A compliance visit was carried out in October by the NHSCFA compliance and accountability team. The result of this visit was positive. The written report in relation to the work carried out by NHS Wales Counter Fraud teams is due but has not yet been received.

To comply with the organisational risk management policy a new system of reporting has been introduced. A new Fraud Risk Assessment Document that complies with local procedure has been developed and implemented. All fraud risk work is now reported on the CLUE case management system and each report remains open with a review date placed upon it. This is to ensure that fraud risks remain under constant review. Every fraud risk that is assessed is now reported to relevant stakeholders by way of the new document. Requests are then made for this risk to be added to the local risk register. All fraud risk assessment work is reported to the Audit Committee by way of quarterly progress reports. Further in-house training has been provided to staff to ensure consistency in approach.

This is reported as partially compliant because of some risks not being added to the local risk register. All other areas of this work are fully compliant with the NHS CFA requirements.

It is anticipated that the All-Wales risk reporting module on Datix will be introduced this year that will add further assurance to this model.

AMBER

- Annual Action Plan

  An annual action plan has been completed for the year ahead that has been produced in direct alignment to the new Government Standard 13. This document has approval / agreement and sign off from the Director of Finance and has been submitted to Audit Committee for approval. Progress of the LCFS teams work will be reported periodically at the Audit Committee.

Due to the nature of Counter Fraud work the plan remains flexible and subject to change throughout the year as new risks and requirements are identified, and investigation referrals received.

GREEN

- Outcome Based Metrics

Throughout the year new data systems have been developed and implemented with the aim of assisting in recording the work of the LCFS team. These new systems supplement existing systems such as ESR, CLUE case management, NFI, and All Wales Statistical reporting. These are constantly measured and statistics produced as at Appendix 1. This has been carried out in the areas of raising awareness, investigation, risk, awareness, joint working, strategic planning, sanctioning, and financial loss and recovery. The service has been successful in documenting direct results. The collection and review of these figures aims to identify the effectiveness of the team and its activity in all areas of its work with a view to the identification of areas that are proving effective and areas that may require further resource or improvement.

GREEN

- Reporting Routes

Staff and contractors have been made aware throughout the year of the reporting routes available to them. In the last year these included direct contact with the team via email, phone and in person, the use of the online CFA reporting tool, the National Reporting Hotline maintained by Crime stoppers, and an internal reporting interactive form. All instances of fraud reporting have been initially assessed and those that are furthered to formal investigation have been recorded on the case management system (CLUE) and reviewed accordingly. New reporting methods introduced this year involving QR coding, generic email address and Interactive Referral forms have proven effective. They have been publicised by way of the Intranet system, the Counter Fraud Intranet Suite, placement of posters at key venues, Fraud Pop Up stalls, screen saver messaging, all staff News emailing and via awareness sessions. This will continue throughout the upcoming year.

GREEN

- Reporting Identified Loss

The CF team has reported all incidents of suspected fraud, bribery using the CLUE management system that was introduced on 9th April 2021. This reporting tool is used to record all investigations, sanctions, recoveries and losses and has a mechanism to record system weakness and Local Proactive Exercise work. This system has been supervised by CFS Wales and all information has been used to inform progress reporting to Audit Committee and CFS Wales. All identified loss to fraud is reported in the Annual report. This year for the first time, in compliance with the NHS CFA requirements, figures in relation to prevention have also been recorded and are reported in the body of this document.

GREEN

- Access to trained investigators

At the start of the year the organisation employed three fully trained and accredited investigators (ACFS) and one fully qualified investigator undertaking accreditation. This accreditation was achieved in July 2022. During the year one full time team member left for another role. This resulted in the team being understaffed by 25% for a period of time totalling one quarter. A recruitment campaign successfully attracted a new team member that commenced in the role in January 2023. This team member is already qualified and accredited. Therefore, at the close of the financial year, the team is made up of four qualified and accredited Counter Fraud Specialist investigators.

GREEN

- Undertake Detection Activity

Where anomalies have been identified through counter fraud work e.g. investigations, the CF team strives to carry out detection activity to assess whether there are any weaknesses present. Where this is the case corrective activity is proactively undertaken to mitigate the identified risk. Regular liaison has taken place with the head of internal audit. Data mining has also been undertaken within the context of the NFI database and all investigations carried out in relation to the 2020-2021 exercise have now been successfully closed. The new NFI exercise went live on 27th January 2023 and the investigation of high-risk matches has begun. All referrals to the team have been fully investigated. All actions taken by the CF team in relation to work in this area have been reported accordingly on CLUE inclusive of any recoveries/preventions made. As investigations and risk

assessment work is carried out throughout the year any necessary proactive detection work will be undertaken.

GREEN

- Access to and Completion of Training

Due to the aftermath of the COVID situation fraud awareness sessions to staff members continue to be disrupted. However, the team have successfully commenced a program of in person sessions to different staffing cohorts. Remotely delivered sessions have continued in support of this. A new program of remote webinar Fraud Training Sessions and Q and A sessions have been developed and implemented and are open to all members of staff within the organisation. They take place twice a month focussing on General Fraud Awareness and Mandate fraud awareness every other week. It is too early to measure how effective this roll out will be. This requires pre-registration and continues to be advertised throughout the organisation via the communications department.

All wales fraud awareness training has remained available throughout the year via ESR. The report at Appendix 1 shows the uptake of this training module. This module remains non-mandatory training.

A counter fraud newsletter has been published quarterly to keep staff appraised. CF team staff have attended all sessions of training provided by CFS Wales and NHS CFA and several webinars from NHS CFA have also been undertaken in relation to update training into areas such as risk assessment and CLUE implementation. A full breakdown of Staff CPD undertaken is provided at within the report at Appendix 1.

GREEN

- Policies and Registers for Gifts and Hospitality and Conflicts of Interest

The organisation has in place policies and registers in compliance with this requirement. The register of Conflicts is managed by the Director of Governance and where appropriate liaison with CF can be sought.

GREEN

3. Allocation of Resources

At 31st March 2023 **108** days of Counter Fraud work have been completed against the agreed 110 days in the Counter Fraud Annual Work-Plan for the 2022/23 financial year as shown below. The days have been used investigating allegations of fraud; interviewing witnesses; preparing, delivering and analysing the feedback from the fraud awareness presentations; preparing quarterly and annual reports for, and attending, the organisation's audit committee meetings; and carrying out a risk assessment activity, developing the organisational Fraud Risk profile and commencing informed fraud risk work.

Strategic Requirements 30 Days

(Inclusive of corporate governance undertaking, attendance of departmental team at staff training events, report writing, planning and attendance all Wales meetings.)

Proactive Work 50 Days

(Inclusive of fraud awareness sessions, and publicity work such as newsletters and bulletins, detection work including PPV review, system weakness reviews and reporting, Local Proactive work e.g. pre-employment Risk Assessment. NHSCFA procurement exercise, and National Fraud Initiative work.)

Reactive Work 28 Days

(Inclusive of the investigation of all referrals, attendance at court hearings, preparation of reports for disciplinary processes, preparation of reports for professional body investigations.)

4. Summary of Costs

Total Costs	**£ 30,607**

5. Breakdown of Investigative work areas

On 1st April 2022 a total of (1) investigation was open and being investigated by the team. This case has since been closed. A disciplinary sanction was applied in this case.

During this financial year a total of (4) new referrals were received and investigated by the team. One (1) of these cases was informally resolved without the need to promote to formal investigation. A total of (3) cases were promoted to formal investigation. These cases were fully investigated by the team and in each case no further action was required. As a result a total of (0) cases remain open as at 31st March 2023.

A summary is provided below.

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/21/00319	Abuse of Position/ Nepotism	Carried Over - 21/10/2021	19/07/2022	Disciplinary hearing held, subject issues with first written warning which will remain in place until 07/07/2023
INV/22/00582	Receiving care whilst living abroad	24/05/2022	05/08/2022	After assessment by overseas patient team subject was confirmed to be classed as "ordinarily resident" and as such entitled to NHS care without charge.
INV/23/00255	Theft of Oromorph	06/02/2023	13/03/2023	No offence identified - checks completed and no theft of oramorph identified.
INV/23/00431	Barclaycard Fraud	02/03/2023	06/03/2023	Financial loss recovered via card issuer - £163.98

6. Sanctions and Recoveries

During the financial year the team has achieved the following sanctions and recoveries.

Disciplinary Sanctions	**1**
Criminal Sanctions	**0**
Professional Sanctions	**0**
Financial Loss attributed to fraud related activity	**£0**
Financial Recoveries	**£163.98**
Financial Prevention*	**£0**

* As defined by NHS CFA formula and requirement

7. Fraud Awareness

During the period 1st April 2022 – 31st March 2023 a total of (10) awareness sessions were delivered to staff members across the organisation. A total of (38) staff were presented to. The feedback from these presentations was positive.

8. Fraud Risk Assessments

During the year a Fraud Risk Profile has been developed for the organisation. This has been presented through audit committee. It is intended to be a live document subject to review. As it develops, it will inform future detection and compliance activity via the use of Local Proactive Exercise. The Fraud Risk Profile details the risks identified as inherent to the organisation as identified by the NHS Counter Fraud Authority and the local Counter Fraud Manager. Local/Specific risks will be added to the profile as they arise. These will be informed externally by Fraud Prevention Notices, and intelligence from other agencies and organisations; and, internally, from identified system weakness reporting post/during investigation work.

During this year the following subject areas have been subject to Fraud risk assessment work by the team:

- Mandate Fraud
- Cyber Mandate Fraud
- Staff Expenses
- Credit Card Usage
- Pre employment

9. Lines of Reporting

CEO – Steve Ham

Executive Director of Finance – Matthew Bunce

Counter Fraud Manager – Gareth Lavington

LCFS – Nigel Price

LCFS – Nicola Tillings

LCFS – Henry Bales

10. Executive Sign Off / Declaration

I declare that the Counter Fraud work carried out on behalf of Velindre UNHST for the year 2022/2023 has been reviewed against the NHSCFA requirements (as stipulated in the Government Functional Standard 13). The ratings that have been achieved are reported above and meet that standards set as shown.

Executive Director Finance: Matthew Bunce

Date: 23/03/2023

Annual Counter Fraud Report

01/04/2022 - 31/03/2023

APPENDIX 1

Performance Charts

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Contents

Figure 1 – Planned Days vs Actual Days Provided by Counter Fraud Team - 2022-23 (All Organisations)

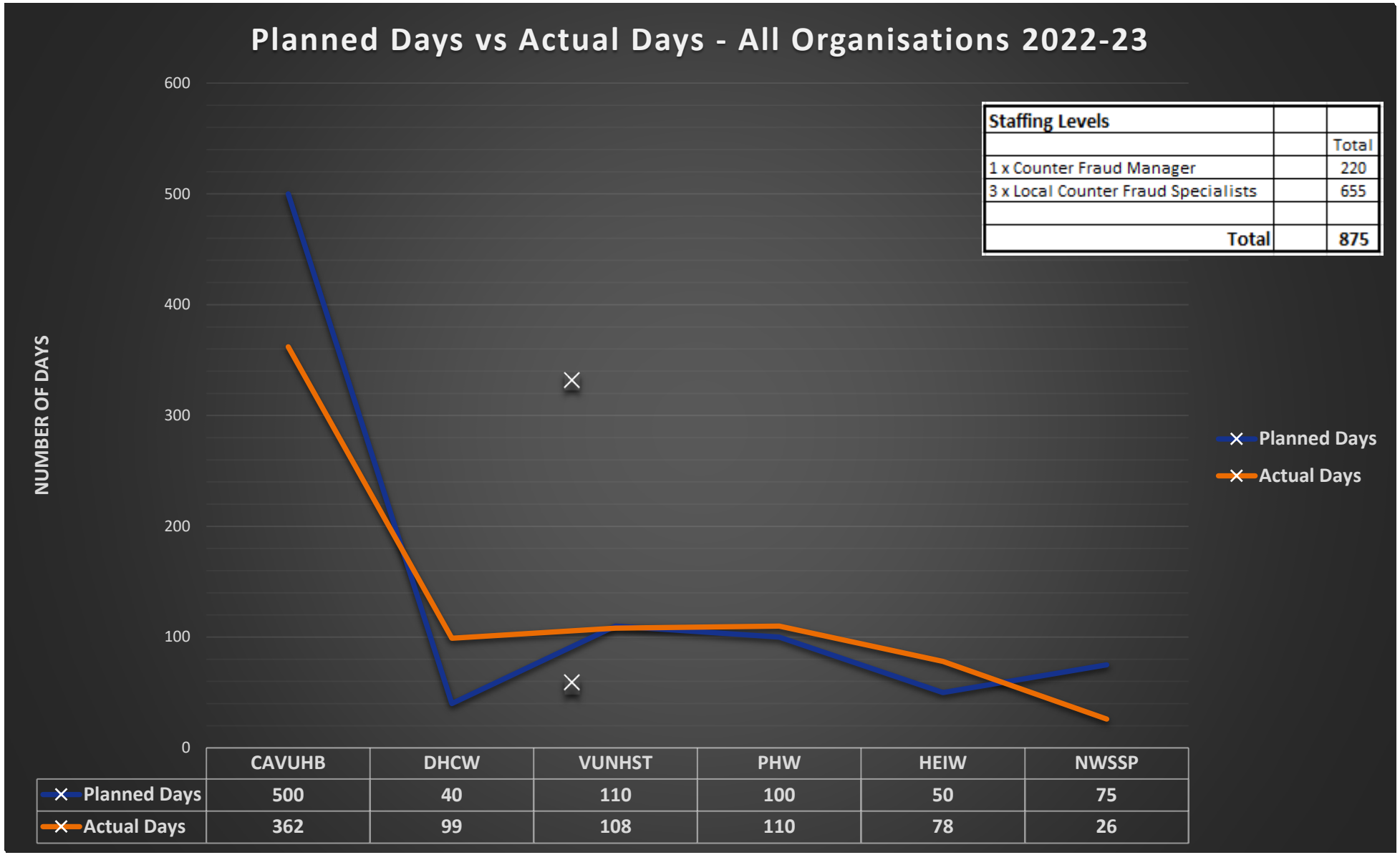


Figure 2 – Referral Forms Submitted to Counter Fraud Team - 2022-2023

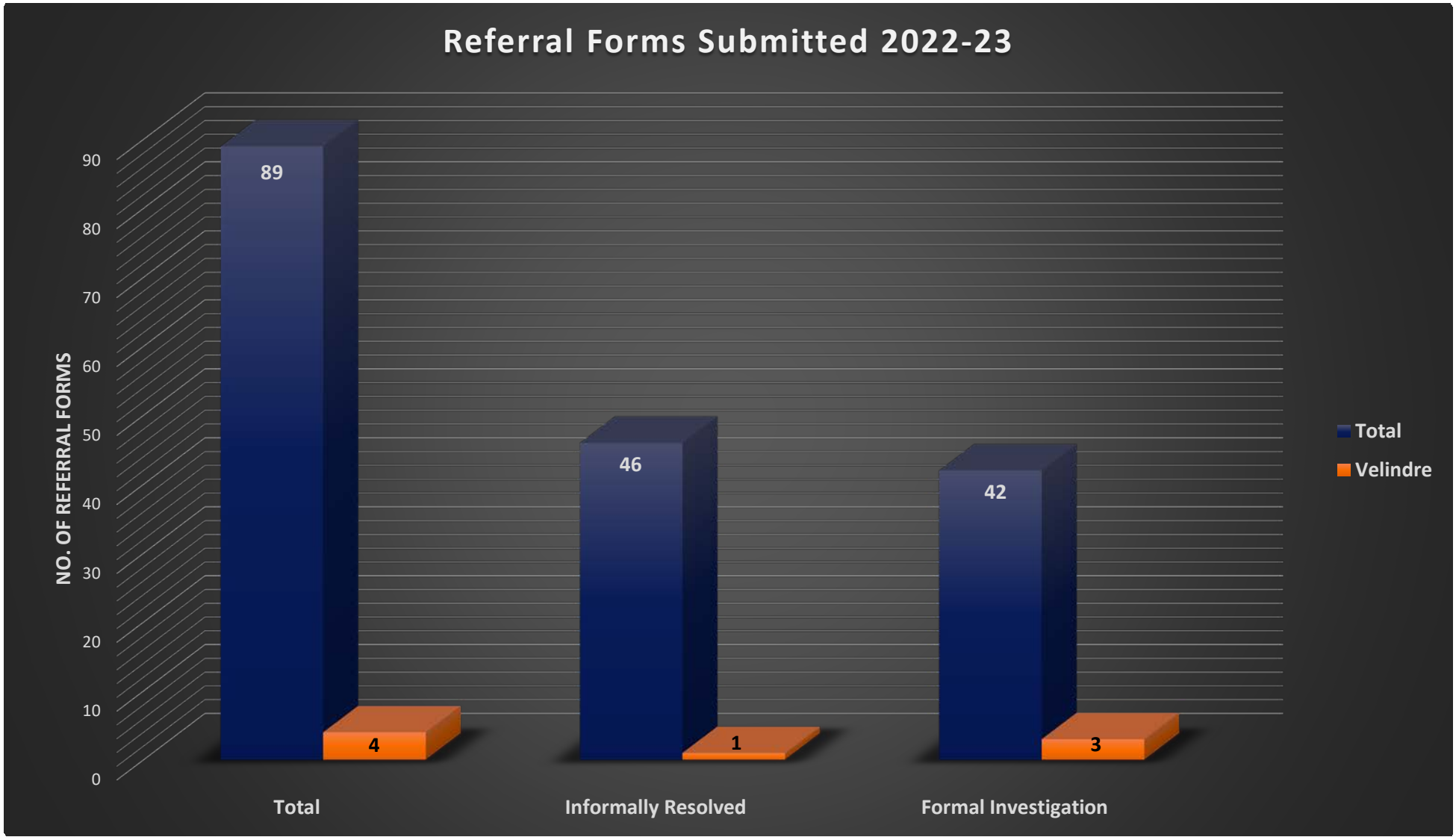


Figure 3 – Investigation Outcome Breakdown 2022-23 (All Organisations)

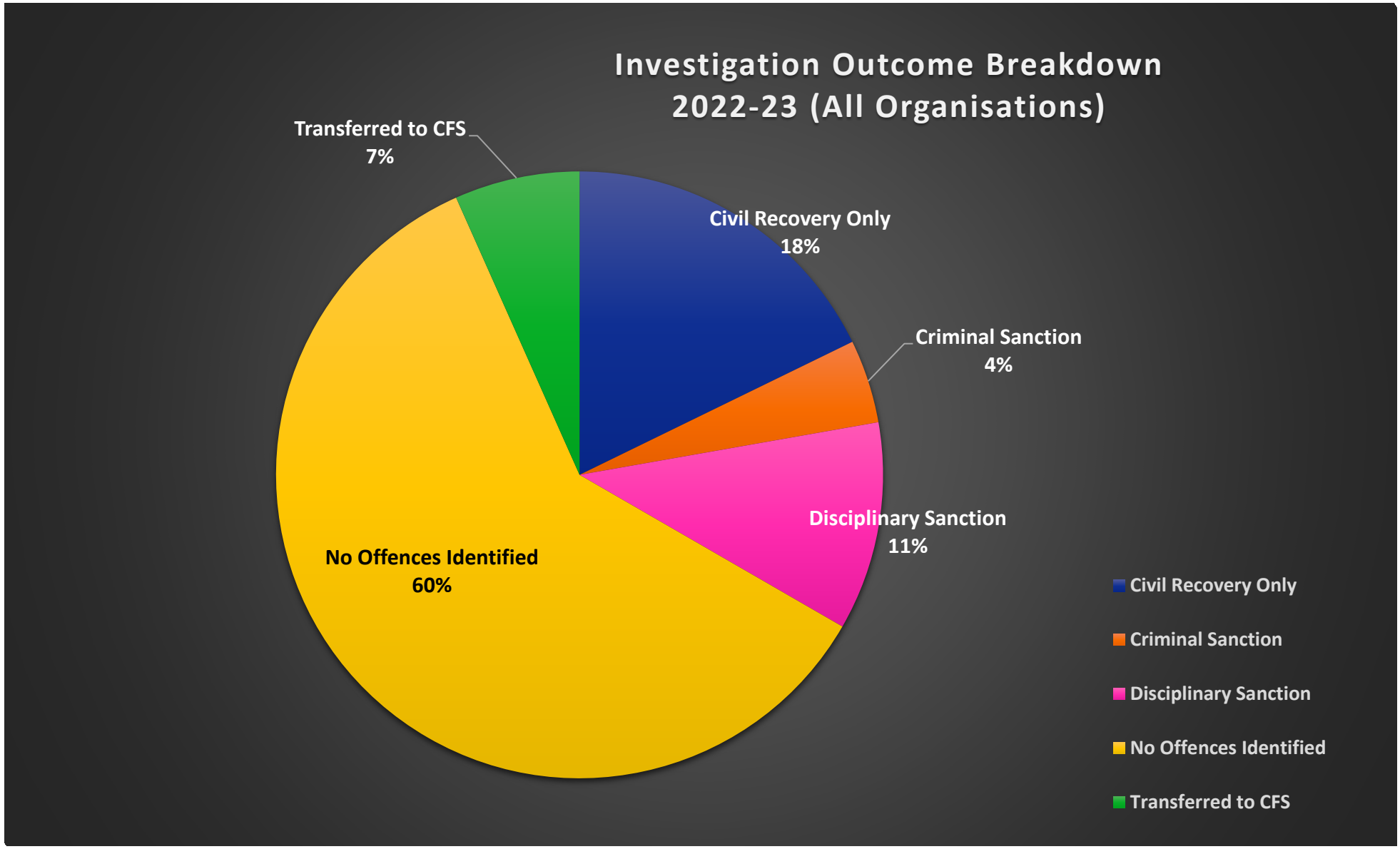


Figure 4 – Fraud Awareness Sessions by Type – 2022-23

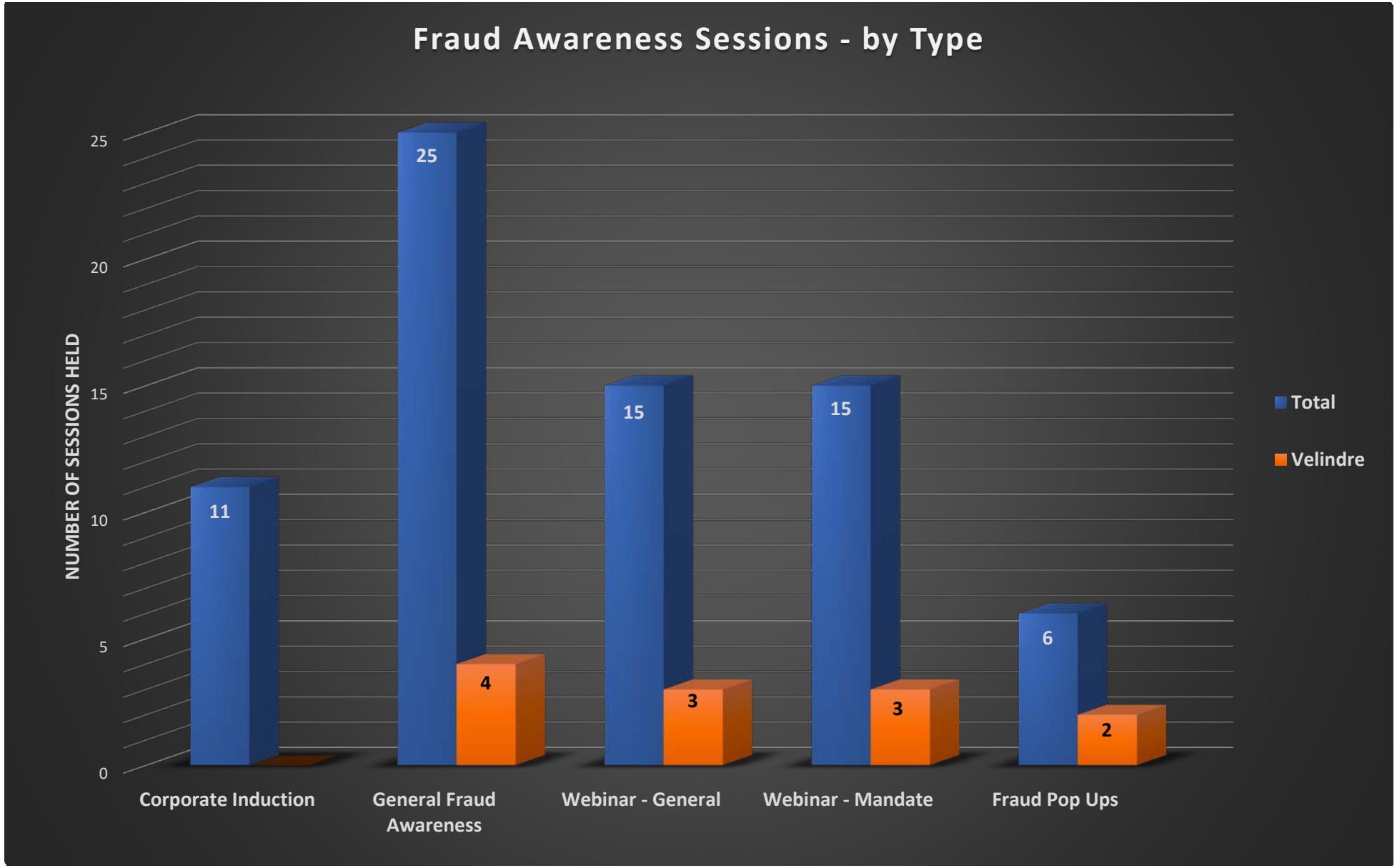
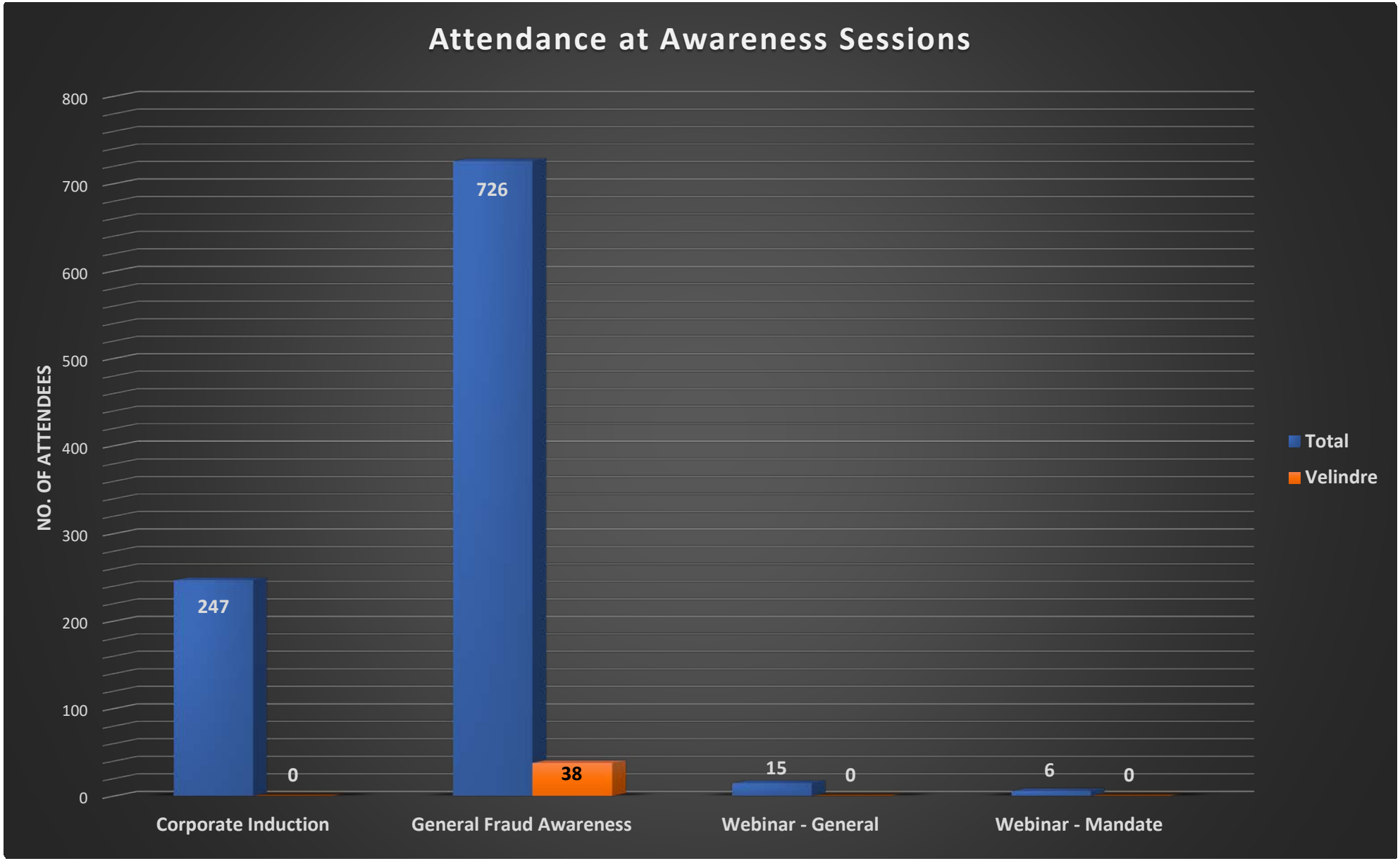


Figure 5 – Attendance at Awareness Sessions – 2022-23



NHS WALES
Velindre University NHS Trust

COUNTER FRAUD WORK PLAN
2023/2024

Gareth Lavington
Manager Counter Fraud

This document is prepared by the Cardiff and Vale University Health Board Counter Fraud Team on behalf of Velindre UNHST to comply with Government Functional Standards and the recommendations of the NHS Counter Fraud Authority for NHS Bodies (Wales) and has been approved by the Executive Director of Finance as below.

Workplan prepared by:

Counter Fraud Manager – Gareth Lavington

Workplan agreed by:

Executive Director of Finance – Matthew Bunce

Date: 23/03/2023

WORKPLAN 2022-2023

Background

On 29th January 2021, the NHS rolled out new counter fraud requirements for NHS-funded services in relation to the **Government Functional Standard GovS 013: Counter Fraud.** The NHS Counter Fraud Authority (CFA) worked closely with a wide range of stakeholders to ensure that the NHS Counter Fraud Requirements had greater consistency and remained fit for purpose for organisations, including providers and commissioners. The standards apply to all NHS funded services (those receiving partial or full NHS funding). The purpose of the Government Functional Standard is to set expectations for the management of fraud, bribery and corruption risk across government and wider public services, and to reinforce the government's commitment to fighting fraud against the public sector. The final engagement which sealed the implementation of the Government Functional Standard GovS 013: Counter Fraud occurred at the All Wales DoF's meeting on 19th February 2021.

The NHSCFA is responsible for leading and influencing the improvement of counter fraud standards across the NHS and will be responsible for ensuring the effective implementation of the NHS Counter Fraud Requirements. The requirements have superseded our own fraud, bribery and corruption standards for providers, commissioners and NHS bodies in England and Wales. The NHSCFA is required to provide assurance to the Cabinet Office of NHS compliance with the Functional Standard. This will be accomplished by the receipt and validation by the NHSCFA of the Counter Fraud Functional Standard Return submitted by organisations providing any NHS funded services. Deadline for submission of this document in relation to this plan is on or about 31/05/2024. The NHSCFA Quality Assurance Programme will enable the analysis of performance of the Counter Fraud team against each requirement. The Counter Fraud Manager will provide a grading of compliance in relation to all areas of the functional standards by way of self-assessment. (Green, Amber or Red). This will be supported internally with the completion of the Annual Report that will align with the same methodology.

To achieve the standards, set by the NHSCFA, Velindre University NHS Trust (VUNHST) follows the Welsh Government Directions on Countering Fraud, Bribery and Corruption within the NHS in Wales and employs a dedicated, professionally accredited team of

NHS Local Counter Fraud Specialists (LCFS). To ensure that the Trust's resources remain resilient to the risk of fraud, bribery and corruption, an Annual Work-Plan is compiled by the Counter Fraud Manager that is agreed by Executive Director of Finance and submitted to the Audit Committee for approval at the commencement of each financial year. The Workplan provided below formulates Local Counter Fraud arrangements for VUNHST for 2023-2024. The tasks outlined will be considered and reviewed throughout the year as the need arises. The plan is intended to provide targets for the year but will remain a living document and subject to change. The effectiveness of the plan will be reported in the end of year Annual Report to Audit Committee and in the NHSCFA Functional Return as referred to above.

This organisation's Work-Plan will directly mirror GovS:13 Standard (Counter Fraud) to maintain consistency with the NHSCFA Counter Fraud Bribery and Corruption Strategy. This in turn supports the objectives set by the Welsh Government.

Taking a risk-based approach to planning local counter fraud work

Locally investigators are in the best position to identify and understand the counter fraud requirements for their organisation. Successful implementation of counter fraud policy relies on the work of the LCFS.
The counter fraud work-plan should be tailor-made and specific to the NHS organisation, for example, carrying out local proactive exercises identified during investigations, or analysis of referrals may show the need for more work on preventing fraud or highlight that awareness is needed in a particular department or staff group.

Meeting key personnel in the health board and using the information from staff surveys are important methods for forming action plans. The responses may also reveal areas of risk highlighting a need for pro-active prevention or detection work. Any risks which are identified by the LCFS will be recorded in line with the local Risk Management Policy and nationally via the CLUE case management system, and they will be shared with the Internal Audit department and reported to the Executive Director of Finance and Audit Committee. The aim is to provide assurance that the risk is being suitably managed and is **owned**. While every effort will be made to identify local risks, it is important that information from outside the organisation is also considered; for example, NHS CFA fraud alerts, and fraud prevention notices, together with identified inherent risks to all NHS organisations. Information received from external sources will be assessed and investigated and any risks identified as pertinent to the organisation will be subject to formal assessment. To help organisations take a risk-based approach to counter fraud work and planning, the NHSCFA has issued

up to date risk assessment advice and training. A dedicated risk matrix scoring system and template have been designed and implemented that comply with Cabinet Office methodology for the purpose of recording and reporting upon fraud risk.

Outcomes/Results

Accurate records of counter fraud work are crucial. They inform upon the effectiveness of work undertaken, assist in the planning of future work and help to identify strengths and weaknesses within the organisation. Accurate records of all work undertaken by the Counter Fraud team for this upcoming year will be kept and updated. These results will be reflected in the quarterly progress reports and end of year annual report.

The Counter Fraud team are aware of the importance of liaison with Internal and External Auditors when planning Local Counter Fraud work to prevent duplication of effort. There are some elements of the Counter-Fraud Work-Plan which Internal and External Auditors may review on a risk basis as part of their own reviews of Governance Arrangements, e.g., Whistle-Blowing arrangements, Declaration of Interests, Gifts and Hospitality. External Auditors will certainly be seeking to gain assurance that Counter Fraud arrangements are robust and the Counter Fraud team will maintain a close working relationship with Wales Audit as required.

Resource Provision

Resource Provision for VUNHST	Days Planned 22 / 23
Counter Fraud Manager and LCFS provision from CAVUHB	110

Resource by Activity

Activity	Days Planned 23 / 24
Proactive	80
Reactive	30
Total	110

With the move to the GovS:13 (NHS Requirements) taking place and old 4 standards of Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account now obsolete, the methodology to be adopted in planning resource time by activity area is simplified into Proactive and Reactive areas. Generally *Proactive* work will involve activities such as fraud awareness, corporate induction, creating e-learning modules, local proactive exercises involving risk assessment. Reactive work will involve activities such as, investigation into referrals received, carrying out system weakness analysis because of investigation findings.

NHSCFA states that Proactive work should not be absorbed by Reactive activity or *vice versa* and to this end NHSCFA strongly encourages Proactive work to be 'ring-fenced'. However due to the dynamic nature of the Counter Fraud environment the plan is intended to be flexible to the needs of the service, so may be subject to review and change where service priorities and risk require. If this occurs, then careful consideration will be given to any changes made and they will be discussed with the Executive Director of Finance as soon as is practicable and reported to the Audit Committee. Any changes to the overall days provided or regarding the areas planned for will be reported in the end of year report and through the ongoing Counter Fraud Progress Reports.

Work Plan Objectives

A work plan with matching tasks/objectives is set out below for each NHS requirement area. Each task/objective relates to a specific standard of compliance or fraud risk area; the work plan has been formulated to support the mitigation of the risk of fraud to the organisation and to ensure compliance with the NHSCFA/Gov requirements.

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
1: Accountable individual NHS Requirement 1A: A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness	Counter Fraud Manager (CFM) to hold regular scheduled meetings with Director of Finance (DoF) - objectives to be reviewed and work to date evaluated. During these meetings ongoing work involving investigations, the promotion of fraud awareness, fraud proofing and risk assessments, policy considerations and Counter Fraud communication strategy to be discussed. CFM to produce the VUNHST Counter Fraud Annual Report & Workplan which is to be agreed with the DoF and ratified by the Audit Committee.	Q1/2/3/4 Q1

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate. NHS Requirement 1B: The organisation's non-executive directors, counter fraud champion, or lay members and board/governing body level senior management are accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery and corruption within the organisation.	CFM to provide quarterly progress reports to DoF and Audit Committee and to present these verbally at Audit Committee. Checks to be carried out by CFM that nominations to NHSCFA are correct, up to date and in order. Report to DoF with outcome. Where necessary and appropriate CFM will have access to one-to-one meetings with the Audit Committee Chairperson and Counter Fraud Champion. In addition to this CFM to attend pre-audit committee meetings with Independent Members. Counter Fraud to remain a standing agenda item at Audit Committee. Counter Fraud Manager to provide written and oral reports to this forum, annually and progressively throughout the year. CFM will address and report to DoF and Audit Committee any matters arising from NHSCFA in	Q1 Q1 Q1/2/3/4 Q1/2/3/4 As required

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the standards set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where standards have not been met.	relation to thematic assessment exercises, matters arising out of Fraud Prevention Notices and national exercises. CFM to liaise with internal partners, including Internal Audit, Workforce & Organisation Development, Communication Department, and other senior management teams as necessary to develop and maintain fit for purpose infrastructure providing a firm foundation for the Counter Fraud provision. CFM to complete annual report to Audit Committee and NHS CFA Functional Standard return.	Q2/Q4 And as required Q1 (24/25)
2: Counter fraud bribery and corruption strategy NHS Requirement 2: The organisation aligns counter fraud, bribery and corruption work to the NHSCFA counter	CFM to ensure that work planned in the Annual Counter Fraud Plan and work carried out remains aligned to the NHS CFA strategy and that the objectives are being met.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
fraud, bribery and corruption strategy. This is documented in the organisational counter fraud, bribery and corruption policy, and is submitted upon request. The counter fraud work plan and resource allocation are aligned to the objectives of the strategy and locally identified risks	CFM to provide assurance that counter fraud provision is resourced by way of qualified, nominated and accredited Counter Fraud Specialists and to ensure that this is maintained.	Q1
3: Fraud bribery and corruption risk assessment NHS Requirement 3: The organisation has carried out comprehensive local risk assessments to identify fraud, bribery and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the	Counter Fraud Department to carry out risk analysis in line with the Government Counter Fraud Profession (GCFP) fraud risk methodology. Locally identified risk to be recorded in line with the organisations Risk Management Policy and entered on to the appropriate risk registers. All risks identified to be assessed and remedial action identified and reported to key stakeholders. All matters arising to be reported to DoF and Audit Committee by way of counter fraud progress reporting.	Throughout the year and dynamically as the needs arise

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body).	Counter Fraud department to continue to develop the fraud risk profile (live document) upon the CLUE case management system to effectively evaluate, evidence and measure the effectiveness of counter fraud risk assessment work.	Q1/2/3/4
For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.	Fraud Risk Assessment action plan/timetable to be devised and developed targeting all areas of inherent Fraud Risk to the organisation (Excluding NWSSP) and providing a timescale of intended work. Proposed action plan to be submitted to Audit Committee for approval/noting.	Q1
	Local Proactive exercises to be undertaken by LCFS as the need arises throughout the year because of local identification or if informed by CFA Fraud Prevention Notices and national exercises.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	All risk analysis work to be subject to timed ongoing review to assess if recommendations acted upon.	
4: Policy and response plan NHS Requirement 4: The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team.	Counter fraud bribery and corruption policy – reviewed amended and updated and approved Q4 22-23: - Counter Fraud (CF) team to promote awareness of the policy at presentations to staff and through newsletters. CF team to utilise staff surveys to evaluate if staff are aware of the policy and how and where to locate it. Also establish that they are aware of the correct procedures associated with reporting fraud, bribery and corruption.	Q1/2/3/4
5: Annual action plan NHS Requirement 5: The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and	CF Manager to complete annual CF fraud workplan detailing planned actions for the coming year. Where possible actions to be given a proposed action time period. CF Manager to ensure the plan is agreed by DoF, ratified by Audit Committee.	Q4 (22/23) Q1

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).	CF manager to provide quarterly reports to Audit Committee and CF quarterly statistics to Counter Fraud Service Wales for onward reporting to Welsh Government. CF manager to provide annual report measuring the effectiveness of the plan.	Q1/2/3/4 Q1 (24/25)
6: Outcome-based metrics NHS Requirement 6: The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking and other comparable data. Proactive and reactive	The new contact, enquiry and reporting methods now in place benefit from the automatic facility of analytical data collection. This will be utilised as an important tool to measure the effectiveness of the actions and work undertaken by the CF Team throughout the year. Where necessary regular review will be used to inform change.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	Maintenance and use of the following resources already successfully implemented will be utilised and improved where necessary: - • CLUE Management System • Interactive feedback forms • Interactive Staff Surveys • Fraud Risk Profile • Risk Management Policy • Locally developed database • Electronic Staff Record • CFS Statistics • Microsoft Share point All investigations will be recorded and Managed on the CLUE case management system and reported to Audit Committee via the quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	All losses, recoveries, outcomes, decisions and criminal, disciplinary and professional sanction will be recorded on the CLUE system and reported to Audit Committee via the quarterly reporting process. This Data will also be shared with the Counter Fraud Service Wales and the NHS CFA. Statistical report of work areas drawn from newly implemented local database to be provided in Annual Report. (To provide work benchmarked year on year)	Q1/2/3/4 Q1 (24/25)
7: Reporting routes for staff, contractors and members of the public NHS Requirement 7: The organisation has well established and documented reporting routes for staff, contractors and members of the public to report incidents of fraud, bribery and corruption. Reporting routes should include NHSCFA's	New reporting routes have been put into place during 2022/2023 that complement existing national routes of reporting. These will be continually 'advertised' throughout the year and awareness will be drawn to them via all routes available. Continued liaison with the communications team will assist in achieving this.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated and updated as required, and levels of staff awareness are measured.	CF team will continue throughout the year promoting their brand identity and presence. This will be undertaken by way of the continued development of the Share point Intranet Site, the all Wales Learning Platform and throughout structured awareness and training sessions and pop-up stalls at key locations. Ongoing review of the effectiveness of the work undertaken and where necessary remedial action to take place dynamically throughout the year. Continuance of promotion of the National Fraud Reporting Line and the National Fraud Reporting tool as managed by the NHSCFA.	Q1/2/3/4 As required Q1/2/3/4
8: Report identified loss NHS Requirement 8: The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and	CF team to make full use of the CLUE case management system for recording and managing Investigations, System Weakness reporting, and Local Proactive exercise reporting.	Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercises	CF Manager to ensure that all members of CF team are suitably trained and qualified to access the CLUE case management system. Review of staff competence to be conducted. CF Manager to supervise the reporting of cases on CLUE ensuring that all referrals are suitably recorded and investigated . CF manager to oversee live investigations on CLUE and appoint Investigating Officer to ensure timely action is taken CF manager to supervise the recording of all proactive work carried by way of Local Proactive exercise/System Weakness reporting. CF manager to ensure that all outcomes by way of sanction, recovery and loss are suitably recorded and	Q2 Q1/2/3/4 Q1/2/3/4 Q1/2/3/4 Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	reported to DoF and Audit Committee at progress updates and at year end in Annual report and NHS CFA Functional Return.	
9: Access to trained investigators NHS Requirement 9: The organisation employs or contracts in an accredited person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery or corruption to account. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements,	The organisation currently employs/has access to provision from, four fully accredited, nominated and qualified LCFS. All members work on a full-time basis. All staff members of the CF team are skilled and trained in criminal investigation and fully up to date with their knowledge of relevant legislation such as PACE, CPIA, DPA, HRA, GDPR, offence legislation. All staff will keep abreast of changes and updates to legislation and undertake training as necessary. All CF staff will continue to develop professionally, attending appropriate training sessions provided by NHSCFA to enhance their knowledge and skills as well as attending regional forums hosted by NHSCFA and	Q1/2/3/4 Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
conducting interviews under caution and maintaining up to date knowledge of legal and procedural requirements.	NHS CFS Wales. CF team will undertake continuing professional development opportunities associated with role throughout the year as they become available. All CF staff to maintain full compliance with mandatory training/e learning as measured on the ESR system. CF team to maintain the appropriate standards of confidentiality and security as well as having access to the tools and resources necessary to professionally carry out their role (inclusive of secure access to relevant IT systems). Review of staff awareness to take place. CF team to continue to maintain access to secure office accommodation accessible only by them. Secure storage facilities both in the office and on site to be utilised effectively for the necessary retention	 Q1/2/3/4 Q2 Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	and storage of evidential data in line with legal requirements. All training and development to be recorded on ESR and referenced during annual staff appraisals.	Q4
10: Undertake detection activity NHS Requirement 10: The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery and corruption. Relevant information and intelligence may include (but is not limited to) internal and	CF team to finalise the work already completed in relation to the Thematic Assessment exercise published by the NHS CFA in 2020. Any work left incomplete to be carried out in period stated. CF team to undertake national exercise work as it is published by NHS CFA throughout the year. CF team to react appropriately to the issue of FPN's from NHS CFA. CF team to react appropriately to fraud alerts raised by other Trusts, Health Boards and Special Health Authorities.	Q1 As required As required

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.	CF team will undertake Local Proactive exercises in response to locally identified risk as the need arises. CF Team to undertake the 2023-2024 National Fraud Initiative exercise in relation to Payroll data CF team will engage with internal and external partners e.g. internal and external audit, to ensure that any outlying data is reported and acted upon accordingly.	As required Q1/2/3/4 Q1/2/3/4
11: Access to and completion of training NHS Requirement 11: The organisation has an ongoing programme of work to raise awareness of fraud, bribery and corruption and to create a counter fraud, bribery and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of	CFM to continue to work towards making Fraud Awareness Training module mandatory. CFM to continue to work towards ensuring that Fraud Awareness training is a standing item of agenda at all corporate inductions. CFM to assist with the smooth roll out of the newly developed All Wales Counter Fraud Training module.	Q1/2/3/4 Q1/Q2

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.	CF team to maintain a promotion strategy in relation to the new module through effective communication to staffing cohorts. CF team to design and implement monthly webinars in relation to General Fraud Awareness Training and Mandate Fraud Awareness Training that all members of staff can register to attend. CF team to develop awareness of the Counter Fraud Department team through all available avenues. To include but not limited to • Digital banners on organisation intranet site • Regular publishing of Counter Fraud news items via Counter Fraud Newsletter • Regular messaging across available social media systems • All staff email bulletins to advise of fraud alerts	Q1/2/3/4 Q1 Implementation Delivery throughout the Year Q1/2/3/4

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
	• Ad hoc and bespoke fraud awareness training for different staff cohorts throughout the organisation including primary care • The use of a Counter Fraud Awareness staffed stand at impactive sites around the organisational estate to provide face to face contact with staff and public promoting the work of the team and its function CF team to fully conversant with the use of the NHSCFA 'ngage' tool in accessing materials and literature suitable for dissemination organisation wide and to the public. CF team to fully participate in National Counter Fraud Week initiative.	Q1/2/3/4 Q3
12: Policies and registers for gifts and hospitality and COI. NHS Requirement 12:	CFM to liaise with Corporate Governance Team to ensure policies are current	Q1

Gov s013 / NHS Requirement	Objective/Action	Proposed Delivery
The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010. The effectiveness of the implementation of the process and staff awareness of the requirements of the policy are regularly tested	CF fraud team to raise awareness of the registers and policies by way of fraud awareness sessions and news bulletins/letters. CF manager to provide a presence and input into relevant policy review, and to record and document changes highlighted through Counter Fraud review. CF team to complete National Fraud Initiative exercise in relation to payroll versus Company Director matches to test effectiveness of declarations of interest policy.	Q1/2/3/4 Q1/2/3/4 Q1/2/3/4

AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING	25/04/2023

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	Commercially Sensitive

PREPARED BY	Ann Marie Stockdale, Head of Outpatient, Medical Records and Private Patient Services
PRESENTED BY	Rachel Hennessy, Interim Head of Operations and Services Delivery
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 the end of November period. Work on December 2022 to March 2023 invoicing is underway and will be completed by June 2023, ensuring the 6 month turnaround time for invoicing with insurers is met.

2.2 There are billing delays due to resourcing issues within the team due to turnover and maternity. Recruitment, as a direct replacement for the Private Patient Medical Secretary, has commenced but it is anticipated that the post will remain vacant for a further six to eight weeks approximately. The temporary cover for maternity leave is no longer in place due to the staff member securing a permanent position within another department of the organisation. The configuration of Team resources are under review to ensure the needs of service are met.

2.3 The reduction in the invoicing timeline has been maintained.

2.4 An external company (Liaison) has been appointment through the procurement route to support delivery of key objectives, including debt recovery. Liaison have been on site and working closely with the Private Patient Team, 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.

2.5 The Private Patient Team in conjunction with Liaison have successfully realised a new income stream via recovery of testing costs. This will contribute to the Velindre Cancer Services Cost Improvement Programme at a minimum £50k per annum recurrently.

2.6 It is anticipated that a proportion of aged debt has been received by the Trust but has not been applied to the Private Patient budget. A cross reference of the Unapplied and Unallocated Reports will need to be completed on a monthly basis to identify this income and resolve this position. This action has been delayed due to staff limitations, though

reviews of the current processes resulted in a corrective actions being undertaken in March period to remove duplication of invoicing and ensure alignment of income expectations.

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

Key Performance Indicators (Targets to be agreed)	31/10/2022	30/11/2022	31/12/2022	31/01/2023	28/02/2023
% Debts Payable by Insurance Companies	97.4%	96.6%	96.9%	97.1%	97%
% Debts Not Payable by Insurance Companies	2.6%	3.4%	3.1%	2.9%	3%
% Debts aged 30 days or less	12.5%	25.2%	25%	35.1%	13.5%
% Debts aged 31-180 days	51.1%	36.3%	38.8%	31.1%	49%
% Debts aged 181-365 days	12.0%	11.1%	10.7%	10.2%	13.1%
% Debts aged 1 year +	24.4%	27.2%	25.6%	23.5%	23.6%

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	31/10/2022	30/11/2022	31/12/2022	31/01/2023	28/02/2023
Days Sales Outstanding	128	117	123	152	150

Key Performance Indicators (Targets to be agreed)	31/10/2022	31/11/2022	31/12/2022	31/01/2023	28/02/2023
Debts recovered in month compared with total debt end of month	-46%	34.9%	20.6%	15.7%	15.3%

2.7 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 97% of private patient income will be derived from insurance companies.

2.8 The total days of sales outstanding has increased due to the aforementioned staffing issues which are being addressed through recruitment. This is also the causation for fluctuating short term debt (0-90 days) variance between Jan and Feb periods.

2.8 The present percentage of debts less than 180 days is 63.4%, which when compared to average of Apr-Sep 2021 (Audited Period of Debts as Reference Point of Base for Improvement) of 45%, reflects a highly significant shift towards "recent" rather than "aged" debt, improving the likelihood of receipt and demonstrable benefit of processes embedded. This is influenced by the high proportion and value of invoices raised during recent months, reflective of the factors raised earlier within this paper.

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

2.9 The Private Patient Team have commenced focus on recovery of debt greater than 180 days and a targeted reduction of the total "Days Sales Outstanding". The contracted in support via LIASON will further support this work in parallel with recruitment to the current vacancies and return of staffing on maternity.

3.0 IMPACT ASSESSMENT

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

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Prompt and efficient recovery of debts is important to the Trust to aid cash flow and reduce the amount of irrecoverable debts.

4.0 RECOMMENDATION

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

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

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Appendix 1 – Aged Debt Report February 2023

Spreadsheet attached.

PP Aged Debt Position February 2(

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)	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
% Debts Payable by Insurance Companies	94.3%	96.8%	93.4%	97.4%	96.6%	96.9%	97.1%	97.0%	
% Debts Not Payable by Insurance Companies	5.7%	3.1%	6.6%	2.6%	3.4%	3.1%	2.9%	3.0%	
% Debts aged 30 days or less	0.0%	47.0%	43.4%	12.5%	25.2%	25.0%	35.1%	13.5%	
% Debts aged 31-180 days	38.2%	17.1%	20.1%	51.1%	36.3%	38.8%	31.1%	49.8%	
% Debts aged 181-365 days	28.2%	16.5%	13.8%	12.0%	11.1%	10.7%	10.2%	13.1%	
% Debts aged 1 year +	33.6%	19.3%	22.7%	24.4%	27.2%	25.6%	23.5%	23.6%	
Days sales outstanding	79	122	52	128	117	123	152	150	

Key Performance Indicators (Tar	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
Debts recovered in month compa	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%

All debts	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
Within maturity (0-30 days)	0	429,597	167,379	118,239	217,211	225,299	392,686	148,938	
31-60 days	48,263	0	58,168	160,372	33,900	147,878	0	257,513	
61-90 days	80,645	48,263	0	241,246	131,489	27,380	201,858	98,580	
91-180 days	55,854	107,641	19,360	79,954	146,922	174,079	146,254	191,621	
181-365 days	136,686	150,957	53,004	113,282	95,449	96,078	114,246	143,511	
1 year +	162,844	176,682	87,363	229,765	234,267	230,611	263,076	259,130	
Total	**484,293**	**913,140**	**385,275**	**942,858**	**861,497**	**901,325**	**1,118,120**	**1,099,295**	

All debts	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
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
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)
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
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)
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)
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
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**

Insured	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
Within maturity (0-30 days)	0	427,667	166,301	118,239	213,176	224,389	387,311	142,008	
31-60 days	48,263	0	58,168	159,294	33,900	143,915	0	257,586	
61-90 days	80,645	48,263	0	241,246	130,411	27,380	197,642	98,580	
91-180 days	50,733	106,410	19,359	79,954	146,922	173,001	145,176	187,613	
181-365 days	131,137	141,686	45,403	108,338	92,573	92,045	114,103	143,368	
1 year +	146,149	159,817	70,644	211,157	215,484	212,430	241,005	237,059	
Total	**456,927**	**883,844**	**359,875**	**918,230**	**832,468**	**873,160**	**1,085,237**	**1,066,216**	

Insured	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
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
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)
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
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)
181-365 days	(20,169)	(50,686)	(6,497)	8,942	(4,775)	4,528	(10,550)	96,283	(62,935)	15,765	528	(22,058)	(29,265)
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
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**

Not Insured (Self payers, Top Ups and Overseas debts, further analysed below)									
Within maturity (0-30 days)	0	1,193	0	0	4035	910	5374	6929	
31-60 days	0	0	1,078	1,078	0	3,963	0	-73	
61-90 days	0	0	0	0	1,078	0	4,216	0	
91-180 days	5,121	1,231	0	0	0	1,078	1,078	4,008	
181-365 days	5,550	9,270	7,601	4,943	5,131	4,033	143	143	
1 year +	16,695	16,865	16,718	18,607	18,782	18,180	22,071	22,071	
Total	**27,366**	**28,559**	**25,397**	**24,629**	**29,028**	**28,164**	**32,882**	**33,079**	

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	30/09/2022	31/10/2022	30/11/2022	31/12/2022	31/01/2023	28/02/2023
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)
31-60 days	915	(4,371)	4,928	(328)	328	0	0	(1,078)	0	1,078	(3,963)	3,963	73
61-90 days	(1,152)	1,302	(3,890)	3,890	(328)	328	0	0	0	(1,078)	1,078	(4,216)	4,216
91-180 days	2,112	(40)	4,384	(3,680)	(415)	(328)	3,890	1,231	0	0	(1,078)	0	(2,930)
181-365 days	(170)	0	(4,892)	116	(448)	0	(3,720)	1,669	2,658	(188)	1,098	3,890	0
1 year +	0	867	(25)	(131)	(855)	0	(170)	147	(1,889)	(175)	602	(3,891)	0
Total	**(977)**	**(5,668)**	**8,530**	**799**	**(1,718)**	**0**	**(1,193)**	**3,162**	**769**	**(4,398)**	**862**	**(4,718)**	**(196)**

Self payer	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
Within maturity (0-30 days)	0	1,930	446	0	4,035	910	1,805	6,929	
31-60 days	0	0	0	446	0	3,963	0	(73)	
61-90 days	0	0	0	0	446	0	4,216	0	
91-180 days	903	903	0	0	0	446	446	3,375	
181-365 days	580	410	1,203	1,053	903	141	143	143	
1 year +	1,086	1,256	1,110	1,491	1,666	726	726	726	
Total	**2,569**	**4,499**	**2,759**	**2,990**	**7,051**	**6,186**	**7,336**	**11,102**	

Self payer	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
Within maturity (0-30 days)	0	(809)	809	0	0	0	(1,930)	1,484	446	(4,035)	3,125	(895)	(5,124)
31-60 days	380	0	0	0	0	0	0	0	(446)	446	(3,963)	3,963	73
61-90 days	(60)	210	0	0	0	0	0	0	0	(446)	446	(4,216)	4,216
91-180 days	(150)	(40)	90	210	(753)	0	0	903	0	0	(446)	0	(2,929)
181-365 days	(170)	0	(260)	(40)	(110)	0	170	(793)	150	150	762	(2)	0
1 year +	0	867	(25)	25	(855)	0	(170)	146	(381)	(175)	940	0	0
Total	**0**	**228**	**614**	**195**	**(1,718)**	**0**	**(1,930)**	**1,740**	**(231)**	**(4,060)**	**864**	**(1,150)**	**(3,764)**

Top Up	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
Within maturity (0-30 days)	0	0	632	0	0	0	3,569	0	
31-60 days	0	0	0	632	0	0	0	0	
61-90 days	0	0	0	0	632	0	0	0	
91-180 days	4,218	328	0	0	0	632	632	632	
181-365 days	4,970	8,860	6,398	3,890	4,228	3,890	0	0	
1 year +	15,609	15,609	15,609	17,116	17,116	17,454	21,344	21,344	
Total	**24,797**	**24,797**	**22,639**	**21,639**	**21,977**	**21,976**	**25,545**	**21,977**	

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

Overseas	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
Within maturity (0-30 days)	0	0	0	0	0	0	0	0	
31-60 days	0	0	0	0	0	0	0	0	
61-90 days	0	0	0	0	0	0	0	0	
91-180 days	0	0	0	0	0	0	0	0	
181-365 days	0	0	0	0	0	0	0	0	
1 year +	0	0	0	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

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

AUDIT COMMITTEE

DEBTS WRITTEN OFF 2022/2023

DATE OF MEETING	25/04/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Claire Bowden, Head of Financial Operations
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Audit Committee regularly receive verbal updates in relation to debts written off during a financial year. At the meeting following the end of the financial year, a written paper is provided to the Committee summarising the total amount written off in the year.

1.2 This year there was also an abandoned claim approved by Welsh Government. Detail is provided in the section below.

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
	£	£	£
NHS England	39,960	0	39,960
	39,960	0	**39,960**

2.2 These debts were included in the 2021/2022 provision for expected credit losses and therefore will not result in an additional charge to the Trust's Income & Expenditure statement for 2022/2023.

2.3 The age range of the debts written off is between the years 2013 – 2019.

2.4 As previously reported to the Committee, the value is made up of 4 debts for organisations in NHS England that are no longer in existence.

2.5 In addition to the write off of these debts, during the year an abandoned claim for legal costs was approved by Welsh Government. The value of that abandoned claim was £337k.

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 a total of £39,960 was written off during the 2022/2023 financial year. In addition, an abandoned claim of £337k was also approved.

4. RECOMMENDATION

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

AUDIT COMMITTEE

PROCUREMENT COMPLIANCE REPORT
3rd December 2022 – 10th April 2023
(Reporting Period)

DATE OF MEETING	25/04/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Nia Price/ Joanne Liddle/ Julie Winterburn
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

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

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Audit Committee with assurance in relation to procurement activity undertaken during the period 3rd December 2022 – 10th April 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 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	11
11.13	Single Quotation Application or Single Tender Application	Single Tender Actions	5
11.13	Single Quotation Application or Single Tender Application	Single Tenders for consideration following a call for an OJEU Competition	0
11.17	Extending and Varying Contracts	Contract Extensions and Contract Change Note (CCN) or Variation of Terms	2
10.4	Departures from SFIs	Award of additional funding outside the terms of the contract (File notes)	5

1.7 Since re-organisation of NWSSP Procurement services in March 2022 Velindre Trust procurement service is provided by the Cardiff & Vale Procurement team for VCS and Corporate Divisions and by Betsi Cadwaladr procurement team for WBS. The nominated Head of Procurement for Velindre Trust overseas and has responsibility for the service provided by these two teams.

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	6	3	9	1
STA's	1	6	7	2
Total	**7**	**9**	**16**	**3**

Repeat Submissions

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

Further Matters / Non-Compliance (Appendix 1.2)

Highlights other procurement matters that are not SQA's or STA's i.e. Contract Extensions, Change Control Notes (CCNs) and Variation of Terms as well as instances where service areas have engaged with providers to supply goods and/or services with a value in excess of £5,000 without following the process outlined in SO's/SFI's and without procurement involvement (File Notes).

Whilst it has been common practice for service areas to undertake competition for the procurement of goods and/or services up to £25,000, it is on the basis that the quotations procedure within SFI's is followed. Where service leads have failed to undertake competition or not sought quotations in accordance with SFI'S there is a breach of SO's/SFI's and File Notes are completed and a record maintained.

All Wales Contracts (Appendix 1.3)

Summarises the All-Wales Contracts that are in progress by NWSSP for information purposes only.

Legislative Regulatory Compliance Register

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

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

2.2 **General Observations Update**

The Procurement department has undertaken a review of the SQA and STA requests that were submitted and approved from 3rd December 2022 – 10th April 2023.

Single Quotation Action (SQA) Requests

9 SQA's were submitted and were considered appropriate, approved and are broken down as follows:

VCC / Corporate (6 SA's)

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

2 x supply of spare parts, consumables and software upgrades for equipment – Only the Original Equipment Manufacturer (OEM) can supply these products/services therefore, given the potential of the on-going requirement, longer-term arrangements should be pursued and will involve engagement with the respective suppliers.

WBS (3 SQA's)

1 x procurement of specialist glass washing equipment - no existing Framework in place for Miele equipment, but Miele confirmed supplier is an approved distributor.

1 x procurement of specialist Dry Block Calibration Device equipment – only one supplier of this equipment

1 x upgrade to specialist Dry Block equipment - OEM Supplier only option for upgrade

Single Tender Action (STA) Requests

For the same period, 7 STA's were submitted and were considered appropriate and approved as follows:

VCC / Corporate (1 STA)

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

WBS (6 STA's)

1 x Purchase of Unlicensed Medicines Factor XI - no authorised equivalent available on the national market. Procured due to valid special clinical needs of patients. This product is bought as part of wholesale service provided by the Trust with full cost of products recharged to Health Boards.

1 x Professional Consultancy work for PBC & OBC Infrastructure Project - Additional piece of work required from the original consultancy firm. It would be uneconomical to appoint new contractor without the background experience of this project.

1 x Supply of armrests for specialist donor chairs - Sole supplier as OEM of chairs only approved supplier of armrests

1 x Procurement of specialist campaign system - From informal discovery sessions held by Department this solution offered best functionality at best value for money

1 x Supply of consumables and reagents for the Beckman Coulter Flow Cytometers – Only OEM consumables and reagents can be used with this equipment

1 x Procurement of a consultant to undertake Apheresis status review - Failed to identify any other Consultant who has the necessary expertise

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

Given the end of year procurement pressures, and following the procurement training being provided, there will be a greater emphasis upon reviewing the aggregated expenditure and undertaking a more focused approach in inviting competitive quotations.

2.2 Other Matters of Interest

` **Trust Board Approvals Process – Update**

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

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies, please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	All policies are equality impact assessed prior to approval.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Any procurement process could be subject to legal challenge where procurement regulations have not been complied with
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	As indicated in Appendices 1.1 (Summary Information of Compliant Arrangements) and 1.2 (Further Matters / Non-Compliant Arrangements) and 1.3 All Wales Contracts

4 RECOMMENDATION

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – April 2023

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible & Manager Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title /Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
Carl James / Jason Hoskins	Velindre Cancer Centre	VCC-SQA-013	01/01/2023 to 01/08/2023	Single Quotation Action	Professional support to Design a Ventilation System for FF Ward and act as the employer's agent. Fulfilling the roles of Architect	HL Design Consultancy Ltd	£24,500.00	Supplier previously completed Ward Refurbishment and have an in-depth knowledge of all aspects of the design.	Endorsed	One-off requirement and not recurring	First Submission
Carl James / Jason Hoskins	Velindre Cancer Centre	VCC-SQA-014	01/01/2023 to 01/08/2023	Single Quotation Action	Professional support to Design a Ventilation System for FF ward and act as the employer's agent. Fulfilling the roles of Building Services Consultant	Consilium Solutions Group LLP	£15,980.00	Supplier previously completed the FF Ward Refurbishment and have an in-depth knowledge of the structural design of this building and completed the feasibility study in support of updating costs for the assessment.	Endorsed	One-off requirement and not recurring	First Submission
Carl James / Jason Hoskins	Velindre Cancer Centre	VCC-SQA-015	01/01/2023 to 01/08/2023	Single Quotation Action	Professional support to Design a Ventilation System for FF Ward and act as the employer's agent. Fulfilling the roles of Structural Engineer.	Bear Structures	£6,500.00	Bear Structures previously completed the FF Ward Refurbishment and have an in-depth knowledge of the structural design of this building.	Endorsed	One-off requirement and not recurring	First Submission
Matthew Bunce / Chris Moreton	Velindre Cancer Centre	VCC-SQA-018	03/01/2023 to 31/03/2023	Single Quotation Action	Production of a policy brief and Theory of Change which helps Velindre University NHS Trust to develop a strategy to establish an agroecological food supply chain	North Star Transition	£24,750.00	Supplier produced feasibility study CTM in May 2022 and therefore has tacit knowledge required to deliver the scope of the policy brief given knowledge and context of the Welsh hospital food system.	Endorsed	One-off requirement and not recurring	First Submission
Paul Wilkins / Helen Payne	Velindre Cancer Centre	VCC-SQA-021	One-off Purchase	Single Quotation Action	MX500 Intellivue Monitor – patient monitor	Philips Electronics UK Ltd	£8,274.41	Equipment is required for the remote monitoring of Cardiac Implanted device function for patients	Endorsed	One-off requirement and not recurring	First Submission

Velindre University NHS Trust - Audit Committee Report – April 2023

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								undergoing Radiotherapy treatment. Equipment matched with patient monitors within the service and wider organisation, therefore minimising the need for additional training, and maximising contingency in the event of monitor malfunction			
Paul Wilkins / Sarah Norman	Velindre Cancer Centre	VCC-SQA-022	01/04/2023 to 31/03/2024	Single Quotation Action	Annual Software License & Support Agreement (Aslsa) Subscription	3M United Kingdom PLC	£24,893.70	Sole supplier, continuation of encoding license and software support.	Endorsed	Procurement to seek longer term agreement	Repeat Submission
Carl James / Daniel Rainbird	Velindre Cancer Centre	VCC-STA-023	01/04/2023 to 31/3/2023	Single Tender Action	Telephone System upgrades and support	Daisy Communications	£52,538.84	MX-ONE Upgrades, and SIP Migration are required to maintain operational and supported telephone systems across the Trust whilst a review of current telephony services is undertaken.	Endorsed	An aim to converge and standardise onto a single Trust-wide telephony platform.	First Submission
Alan Prosser	WBS	WBS-STA-1026	06/01/2023 to 31/12/2023	Single Tender Action	Purchase of Unlicensed Medicines - Factor XI	BioProducts Laboratory	£99,000.00	Unlicensed medicines - no authorised equivalent available on the national market. Procured due to valid special clinical needs of patients. This product is bought as part of wholesale and Health Boards are charged for the products.	Endorsed	Consideration of potential to tender for a Framework Agreement that would remove requirement for Waiver. Framework Agreement would need to be flexible to cover products becoming licensed and then being	Repeat - Previous WBS-STA-882 value to £99,000

Velindre University NHS Trust - Audit Committee Report – April 2023

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible & Manager Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title /Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
										removed from Framework.	
Alan Prosser	WBS	WBS-STA-1029	01/01/2023 to 31/03/2023	Single Tender Action	Consultancy for PBC and OBC support for infrastructure improvements at Talbot Green	Adcuris Consulting Ltd	£25,833.33	Additional piece of work required from the original consultant firm. It would be uneconomical to appoint new contractor without the background experience of this project.	Endorsed	None	First Submission
Alan Prosser	WBS	WBS-STA-1030	One off purchase	Single Quotation Action	Armrests for Blood Donation Chairs	Renfrew Group	£13,680.00	Sole supplier, Renfrew Group manufactured the donation chairs	Endorsed	None	First Submission
Alan Prosser	WBS	WBS-STA-1032	01/03/2023 to 28/02/2024	Single Tender Action	Campaigner - Email system	J2 (Campaigner)	£25,284.00	From informal discovery sessions held by Department this solution offered best functionality at best value for money	Endorsed	Future plan will be to consolidate several campaign projects onto one platform	First Submission
Alan Prosser	WBS	WBS-SQA-1033	One off purchase	Single Quotation Action	Glass Washer Replacement	The Scientific Instrument Centre Ltd	£23,176.33	Critical piece of Miele equipment, no national framework in place and Miele advised approved distributor	Endorsed	None - Capital Procurement	First Submission
Alan Prosser	WBS	WBS-SQA-1035	One off purchase	Single Quotation Action	Purchase of Europa Dry Block Calibration Device	Isothermal Technology Ltd	£13,066.20	Sole Provider	Endorsed	None - Capital Procurement	First Submission
Alan Prosser	WBS	WBS-STA-1042	01/01/2023 to 31/12/2023	Single Tender Action	Supply of consumables and reagents for the Beckman Coulter Flow Cytometers	Beckman Coulter UK Ltd	£201,804.29	OEM consumables	Endorsed	£100k Commitment of Expenditure paper being completed in order to award longer term agreement for future supplies after Dec 2023 either via NHSSC or direct via a VEAT. Equipment, Maintenance contract and certain consumables procured	Repeat - Previous WBS-STA-987 £56,000

Velindre University NHS Trust - Audit Committee Report – April 2023

Appendix 1.1 – Summary Information of Compliant Arrangements

Executive / Director Responsible & Manager Responsible	Division	Procurement Ref No	Period of Agreement/ Delivery Date	SFI Reference	Agreement Title /Description	Supplier	Anticipated Agreement Value (ex VAT) Excluding any Previous Submitted Values	Reason/ Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or Repeat (Previous Cost to Date)
										against NHSBT contract, but this covers those consumables & reagents not included but required. In addition, Beckman have ceased to manufacture DNA Prep and more expensive Leukosure now required	
Alan Prosser	WBS	WBS-STA-1043	01/02/2023 to 31/03/2023	Single Tender Action	Apheresis status review of HB's across Wales	A Bespoke Consultancy Ltd	25,000.00	Failed to identify any other Consultant who has the necessary expertise	Endorsed	None	First Submission
Alan Prosser	WBS	WBS-SQA-1047	One off purchase	Single Quotation Action	QSDX 96 Block Upgrade	Life Technologies (Thermo)	7,392.06	OEM Supplier	Endorsed	None	First Submission

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Velindre University NHS Trust - Audit Committee Report – April 2023

Appendix 1.2 - Further Matters / Non-Compliant Arrangements

Executive / Director Responsible	Division	Procurement Ref No	Period	SFI Reference	Agreement Title/Description	Supplier	Anticipated Agreement Value (ex VAT)	Reason/Circumstance and Issue	Compliance Comment	Procurement Action Required	First Submission or repeat
Paul Wilkins / Helen Payne/Louise Cook	Velindre Cancer Centre	VEL-FN-015	July 2022 – 31 March 2023	File Note	PhD Tuition Fees for Paul Jenkins, Radiotherapy Department	Cardiff University	£16,305.00	Expenditure in 2019, 2020-2021 approved by previous agreement, with line manager at the time Continuation of PhD as of 2022 academic fees, discussed and agreed between interim RSM and Head of Radiation services	Competition not sought in accordance with SFI'S	The longer-term requirement to be discussed with the Head of Radiation Services.	First Submission
Paul Wilkins / Nicola Hughes	Velindre Cancer Centre	VEL-FN-016	N/A	File Note	Introductory fee 2 clinical Oncologists	IMG Connect	£28,000.00	Other recruitment agencies were unable to or only able to provide limited suitable candidates due to the following reasons: • Unsuitable candidates due to bespoke nature of roles • Lack of suitable candidates registered with them • Ability to only provide candidates on a short-term locum basis rather than long term permanent basis • Unreasonable costings offering little value for money	Competition not sought in accordance with SFI'S	No further actions	First Submission
Paul Wilkins / Tim Register	Velindre Cancer Centre	VEL-FN-017	One-Off Purchase	File Note	Replacement iBEAM evo Couch top EP	Elekta Ltd	£11,871.10	SQA was unsigned, the order had to be placed hence File note completed retrospectively	Competition not sought in accordance with SFI'S	No further actions	First Submission
Lauren Fear	Velindre Cancer Centre	VEL-FN-018	One-Off Requirement	File Note	Investigation into confidential matter	Stuart Gray	£8,550.00	Stuart Grey was commissioned to undertake an investigation into a very confidential matter which is being dealt with at Ministerial level. The choice of using him as an investigator was in collaboration with Welsh Government. The original	Competition not sought in accordance with SFI'S	No further actions	First Submission

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
								work was envisaged to be under £5k. However, the investigation became more complex than originally envisaged with several further interviews and length of time to complete the work as a result. This led to be final cost of £8.5k.			
Lauren Fear	Velindre Cancer Centre	VEL-FN-019	One-Off Requirement	File Note	Legal and consultancy advise on new matter	Mills and Reeves	£15,000.00	Mills & Reeve provided initial advice on a very confidential matter which is being dealt with at Ministerial level. Given the speed this needed to be progressed, in the public interest, we have continued to work with Mills & Reeve on this matter.	Competition not sought in accordance with SFI'S	No further actions	First Submission
David Powell / Mark Ash	New Velindre Cancer Centre	VEL-FN-020		Contract Extension	Provision of architectural consultant (Tier 1) support for the nVCC projects	John Cooper Architects Ltd	£20,000.00	In June 2021, the order value was increased by £20k. This was within the Procurement Regulation 72 guidelines	CCN Approved	The Trust has completed the procurement process and the Trust Board has approved to award a new contract to JCA Ltd from April 2023.	First Submission
David Powell / Mark Ash	New Velindre Cancer Centre	VEL-FN-021		Contract Extension	Provision of architectural consultant (Tier 1) support for the nVCC projects	John Cooper Architects Ltd	£50,000.00	A further extension to the contract with the supplier up to the 50% value permitted by Reg 72. The Trust has completed a procurement process and the Trust Board has approved to award a new contract to JCA Ltd from April 2023. This is to ensure continuity of service is provided, avoiding any further delay to the nVCC project will affect achieving Financial Close and the opening of the new Velindre Hospital.	CCN Approved	The Trust has completed the procurement process and the Trust Board has approved to award a new contract to JCA Ltd from April 2023.	Repeat Submission

Velindre University NHS Trust - Audit Committee Report – April 2023

Appendix 1.3 - All Wales Contracts in progress

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.	Wheelchair seating contract encompasses a range of wheelchair seating and positioning equipment such as seat cushions, back cushions, seating systems (including bespoke provisions) and postural supports	briefing	£ 2,881,960	20/01/2023	27/01/2023	n/a	n/a
2.	Ultra-High Resolution Human Leukocyte Antigen (HLA) Typing for the Welsh Bone Marrow Donor Registry The service currently provided is HLA tissue typing for all relevant genetic markers to facilitate a stem cell transplant. For blood samples the supplier is required to also supply CCR5 testing result. For swab kit samples the supplier is required to provide CMV testing results and ABO/Rh results	briefing	£ 960,000	22/12/2022	n/a as below £1M	n/a	n/a
3.	Care Homes FA procurement for a Framework Agreement for the provision of Services by independent providers to younger adults (18+) in mental health and learning disabilities care homes and care homes with nursing.	extension	£ 339,000,000	30/12/2022	original approval applies 28/9/16	20/01/2023	20/01/2023
4.	Frozen Foods & desserts The meals are used for patient feeding and are utilised within all Health Boards across Wales, with the meals consisting of frozen-plated, multi-portion, texture modified, cultural and children's meals.	extension	£ 7,035,091	20/01/2023	original approval applies 25/03/2021	23/01/2023	17/02/2023
5.	Sevoflurane is a rapid acting volatile liquid anaesthetic, used for the induction and maintenance of general anaesthesia. A specially calibrated vaporiser is used for its administration.	briefing	£ 1,748,736	20/01/2023	01/03/2023	n/a	n/a
6.	Wheelchair reconditioning provision of several categories of reconditioning and decontamination of manual and powered wheelchairs	ratification	£ 1,383,141	20/01/2023	26/01/2023	27/01/2023	27/01/2023
7.	Alternative Radiology reporting service the purposes of reporting which has an exclusivity clause which prohibits the use of alternate provider(s) unless the provider advises of an inability to meet the demand on a monthly basis. Therefore, this contractual agreement is required to meeting any shortfall in the incumbent providers ability to meet all requested non-urgent reporting, within the monthly client demand forecast, Health Boards and Trusts will be able to seek the support of alternate provider(s) for that the unabsorbed demand.	ratification	£ 646,944	25/01/2023	30/01/2023	n/a	n/a
8.	Emergency Department Well-being and Home Safe Service The purpose of the pilot scheme was to offer support for frail older people and vulnerable adults in emergency departments and to resettle people in their homes with follow-up welfare calls or visits and where necessary to connect them to community services to avoid readmission into the emergency department.	extension	£ 2,622,851	01/02/2023	original approval applies 12/2/21	01/02/2023	01/02/2023
9.	Maintenance of MRI Sola Fit Scanner - Cwm Taf Morgannwg Provision of regular servicing, corrective maintenance visits to site and the supply and fitting of replacement parts, including specialist elements and hardware and software upgrades for the life of the contract.	ratification	£ 562,707	06/02/2023	13/02/2023	n/a	n/a

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+
10.	Laparoscopic consumables Framework for the provision of Laparoscopic Instruments and Consumables including Staplers and Clip Appliers, Instruments, Accessories, Kits, and Advanced Energy Devices	ratification	£ 28,459,599	07/02/2023	17/03/2023	17/03/2023	28/03/23
11.	Lymphoedema including compression garments such as off the shelf and made to measure upper and lower limb garments (arm sleeves & stockings) for the treatment of various types of oedema, but also includes products such as compression wraps, glue and donning/doffing aids	ratification	£ 6,557,904	06/02/2023	17/03/2023	17/03/2023	28/03/23
12.	Influenza Vaccine Season 2023 contract is for the Seasonal Influenza Vaccine 2023 for the occupational health departments in the Hospitals on an all-Wales basis.	ratification	£ 1,005,433	14/02/2023	08/03/2023	07/03/2023	09/03/2023
13.	Haemostatic products provision of products used to promote haemostasis where suturing or other conventional methods would not be effective enough	extension	£ 5,172,581	10/02/2023	original approval applies 30/8/18	27/03/2023	27/03/2023
14.	Breathing circuits & accessories and breathing filters masks & accessories A breathing system is an assembly of components which connects patient's airway to an anaesthesia machine through which a controlled composition of gas mixture is dispensed. It delivers gas to the patient, removes expired gas and controls the temperature and humidity of the inspired mixture.	extension	£ 4,200,000	10/02/2023	original approval applies 16/2/18 & 28/11/16	27/03/2023	27/03/2023
15.	Laparoscopic instruments and consumables Laparoscopic Surgery is a minimally invasive surgery which involves a small incision on the abdomen to allow a surgeon to access the inside of the abdomen and pelvis.	extension	£ 34,371,647	10/02/2023	original approval applies 17/10/17	27/03/2023	27/03/2023
16.	Laryngoscope Blades & Associated Consumables provision of Laryngoscope blades, video laryngoscope blades and consumables	extension	£ 2,500,000	10/02/2023	original approval applies 27/4/18	27/03/2023	27/03/2023
17.	Vascular Access Accessories The contract allows user to purchase Vascular Access Accessories including connectors, filters, administration sets, blood sets, pressure tubing, extension sets including needle free access devices.	extension	£ 17,200,000	10/02/2023	original approval applies 12/10/16	27/03/2023	27/03/2023
18.	Wristbands A Patient identification wristband refers to the ID bands that are issued when patients are admitted into Hospital	extension	£ 1,500,000	10/02/2023	original approval applies 31/3/17	27/03/2023	27/03/2023
19.	Chest & Wound Drainage Chest Drainage products are a conduit to remove air, blood, pus or fluid from the pleural/thoracic cavity	extension	£ 2,320,704	10/02/2023	original approval applies 18/3/19	27/03/2023	27/03/2023
20.	Airway management The Airway Management agreement consists of items that are required to undertake an array of medical procedures that prevent airway obstruction or asphyxiation. Most commonly the items are used to ventilate the lungs of critically ill patients or those that have been anaesthetised to carry out a procedure.	extension	£ 700,000	10/02/2023	original approval applies 25/4/17	n/a	n/a
21.	Maintenance of MRI Sola Fit Scanner - BCU Provision of regular servicing, corrective maintenance visits to site and the supply and fitting of replacement parts, including specialist elements and hardware and software upgrades for the life of the contract.	ratification	£ 588,879	10/02/2023	15/02/2023	n/a	n/a
22.	Enteral Feeding consists of items that are required to feed patients via their nose, directly into their stomach or directly into their small intestine, due to malnourishment or chronic disabilities	extension	£ 4,233,199	21/02/2023	original approval applies 18/7/17	27/03/2023	27/03/2023
23.	Ambient Groceries supply of ambient food and drink products to all NHS Wales Health Boards and Trusts.	ratification	£ 15,729,474	22/02/2023	sent to WG 22/2		
24.	Wound management ongoing treatment of a wound by providing an appropriate environment for healing, via both direct and indirect methods, together with the prevention of skin breakdown.	extension	£ 2,290,873	22/02/2023	original approval applies 5/10/16	27/02/2023	27/02/2023
25.	Framework for Insourcing/Outsourcing of Clinical, Surgical and Diagnostic Procedures The scope of the framework covers a wide range of major diagnostic and clinical procedures potentially required by Health Boards. These include Breast, Cardiac & Cardiology related Diagnostics, Cardiology & Cardiology related Diagnostics, CT Scanning, Dermatology, Ear,	ratification	£ 200,000,000	23/02/2023	27/02/2023	28/02/2023	28/02/2023

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+
	Nose & Throat, Endoscopy (including Cystoscopy), Gastroenterology, General Surgery, MRI Scanning, Neurology & Neurology related Diagnostics, Neuroscience, Non-Obstetric Ultrasound, Oral Maxillo Facial Surgery, Orthopaedic Surgery, Pain Management, Plastic Surgery, Thoracic Ultrasound Diagnostics, Urology and Vascular						
26.	Breathing systems & consumables contract allows the users to purchase their anaesthetic face masks, breathing filter sets and components, catheter mounts, breathing circuits, gas sampling lines, tube supports, oxygen enrichment device, reservoir bags, BVM's, and anaesthetic connectivity consumables through a compliant all Wales agreement.	ratification	£ 2,604,577	22/02/2023	21/03/2023	21/03/2023	21/03/2023
27.	Stoma Care Support Services deliver value to those receiving stoma care services and to build on the existing arrangements by delivering a range of benefits across Wales.	ratification	Income generation - £14,137,284.00 Prescribed items - £125,000,000 Delivery & Preparation - £17,500,000	27/02/2023	23/03/23	27/03/2023	27/03/2023
28.	Heparins Anticoagulants, commonly known as blood thinners, are chemical substances that prevent or reduce coagulation of blood, prolonging the clotting time. Anticoagulants interfere with the proteins in your blood that are involved with the coagulation process. These proteins are called factors. Different anticoagulants interfere with different factors to prevent clotting.	extension	£ 32,804,340	01/03/2023	original approval applies 15/4/20	02/03/2023	02/03/2023
29.	GP Reporting tool - locum hub The contract provided by GP Wales enables an interface with existing NHS Wales primary care infrastructure and that of third-party solutions. It delivers integrated solutions for practices that work across clusters; to support multi-disciplinary deployment of the workforce and provide a source of intelligence to inform the development of the wider primary care workforce thus ensuring a more robust approach to workforce planning and reporting to Welsh Government	extension	£ 759,000	01/03/2023	original approval applies 8/1/20	02/03/2023	n/a
30.	Urine Meters A Urine Meter is a device that accurately measures urine output. They are commonly found in a surgical and intensive care setting. Urine output is the best indicator of the state of a patient's kidneys; if an adequate amount of urine is being produced, the kidneys are well perfused and oxygenated	briefing	£ 761,750	01/03/2023	n/a as below £1M	n/a	n/a
31.	All-Wales Hospital Medical Record Forms provision of All-Wales Hospital Medical Record Forms (HMR's)	extension	£ 1,303,200	03/03/2023	original approval applies 24/3/21	03/03/2023	06/03/2023
32.	Supply of Computer Consumables purchase a mixture of original branded, compatible and remanufactured cartridges to meet their individual requirements.	briefing	£ 3,600,000	03/03/2023	N/A direct award from framework	n/a	n/a
33.	Ultrasound & Decontamination Managed Service Contract The contract will include Equipment Hardware, Software, Implementation, onsite support and maintenance and Decontamination included as part of the managed service with clear KPIs and Contract Terms designed to keep the Health Board at low risk of clinical downtime and service delays	briefing	£ 10,396,353	09/03/2023	sent to WG 9/3	n/a	n/a
34.	Provision of Cleaning and Security Services provision of general office cleaning and security services	ratification	£ 12,046,062	06/03/2023	N/A direct award from framework	17/03/2023	28/03/23
35.	Clinical Waste Sharps Containers The range of products available on the contract evolve in line with healthcare requirements and legislation to cover the safe disposal of clinical sharps in all clinical circumstances and are available in a wide variety of plastic moulded items. Bins come with colour coded lids to aid waste segregation, an essential aspect of the contract. A selection of waste stream colour coded Cardboard boxes has also been introduced to the contract in	briefing	£ 1,300,000	06/03/2023	N/A direct award from framework	n/a	n/a

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+
	recent years, providing a cost saving and sustainable approach to the disposal of items such as administration sets and non-sharps items. Disposal through cardboard boxes rather than plastic boxes is more environmentally friendly and cost effective						
36.	Clozapine is indicated for the treatment of schizophrenia (including psychosis in Parkinson's disease) in patients unresponsive to, or intolerant of, conventional antipsychotic drugs.	ratification	£ 1,771,580	06/03/2023	20/03/2023	21/03/2023	21/03/2023
37.	Hep C This contract is for the provision of antiviral medicines for the treatment of Hepatitis C (HCV). These medicines are designed to stop the virus from multiplying inside the body and thereby preventing liver damage. The World Health Organisation has a strategy to eliminate HCV as a significant public health threat by 2030. Treatment using these medicines is in accordance with the WHO strategy	ratification	£ 13,454,112	14/03/2023	27/03/2023	27/03/2023	27/03/2023
38.	Occupational Health AW056 a contract with Cority Cohort to provide Occupational Health services to Health Boards in Wales. The contract is administered by NWSSP Digital Workforce on behalf of participating Health Boards and license costs are recharged to Health Boards. A new solution was procured in October 2022 in accordance with the Public Contract Regulations 2015 and awarded to Civica UK Limited.	extension	£ 516,000	06/03/2023	original approval applies	n/a	n/a
39.	Maintenance of Star Guide Spect/CT/NM System To ensure that the system in question which is located within Singleton Hospital is serviced on a regular basis and receives all appropriate software updates to function fully, all in accordance with the original equipment manufacturer's recommendations and all applicable guidelines	ratification	£ 536,191	14/03/2023	N/A direct award from framework	n/a	n/a
40.	Erythropoietin Stimulating Agents & IV Iron 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. Iron is very important in maintaining many body functions, including the production of haemoglobin, the molecule in your blood that carries oxygen. Iron is also necessary to maintain healthy cells, skin, hair, and nails.	briefing	£ 7,641,200	14/03/2023	sent to WG 14/3	n/a	n/a
41.	International Nurse Recruitment project This contract is for the continued provision of services to recruit experienced nurses from a range of overseas countries to be deployed across NHS Wales.	ratification	£ 4,360,000	16/03/2023	N/A direct award from framework	16/03/2023	17/03/2023
42.	Cleaning & Janitorial Products (NPS Framework) This would comprise of – Catering Chemicals Cleaning Chemicals/Detergents - other Janitorial products (including Micro Fibre products)	briefing	£ 3,145,833	20/03/2023	N/A direct award from framework	n/a	n/a
43.	Pathology Consumables, equipment & instruments The All-Wales Pathology Consumables, Equipment, and Instruments Framework Agreement will be utilised by a range of Laboratories across Wales, including Blood Science, Histopathology, Microbiology, Public Health Wales (PHW), and Welsh Blood Service (WBS).	briefing	£ 12,481,012	16/03/2023	sent to WG 16/3	n/a	n/a
44.	AW069 e-scheduling (district nurses) E-Scheduling software enables the District Nursing workforce in Wales to access a mobile app to schedule their visits, moving away from paper or	extension	£ 1,460,701	21/3/23	original approval applies - 1/4/21	22/03/2023	23/03/2023

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+
	spreadsheet-based systems. The technology allows for the intelligent scheduling of staff by matching clinical skills with individual patients' needs. Visits are schedules based on clinical priorities and travel routes are optimised to minimise travel time as much as possible. A live visit status board and staff safeguarding board also ensures real-time tracking of nurses while attending their visits						
45.	Computer Consumables purchase a mixture of original branded, compatible and remanufactured cartridges to meet their individual requirements.	ratification	£ 4,080,000	21/3/23	N/A direct award from framework	22/03/2023	23/03/2023

AUDIT COMMITTEE

DECLARATIONS OF INTERESTS, GIFTS, SPONSORSHIP, HOSPITALITY & HONORARIA (04 OCTOBER 2022 – 18 APRIL 2023)

DATE OF MEETING	25/04/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Not applicable.	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

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 **04/10/2022 – 18/04/2023.**

- There has been **8** new entries on the Gifts, Hospitality and Sponsorship Register this period.
- There have been **32** amendments /additions to the Declarations of Interest this period inclusive of those received via the Trust established Annual Review Process.

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

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	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.
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)
	Please refer to the detail within the registers at Appendix 1 and 2.

4. RECOMMENDATION

4.1 The report is open to the Audit Committee for **NOTING**.

Appendix 1 – Gifts, Sponsorship, Hospitality and Honoraria Register (Additional Entries: 04/10/2022 – 18/04/2023)

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
22/03/2023	Dr Simon Waters	Consultant	Velindre Cancer Service	Gilead Sciences Ltd	23/03/2023	TNBC educational web meeting speaker	Panel member in break out meeting	Honorarium - £930	Own Time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	21/03/2023	Accepted
13/03/2023	Dr Simon Waters	Consultant	Velindre Cancer Service	Gilead Sciences Ltd - Menarini	14/03/2023	Advisory on TNBC educational meetings and programmes	Advisory Board meeting	Honorarium - £900	Own Time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	10/03/2023	Accepted
30/01/2023	Dr Simon Waters	Consultant	Velindre Cancer Service	Gilead Sciences Ltd	02/02/2023	Advisory on TNBC educational meetings and programmes	Advisory Board meeting	Honorarium - £330	Own Time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	30/01/2023	Accepted
17/01/2023	Dr Simon Waters	Consultant	Velindre Cancer Service	Eli Lilly & Co., Ltd	27/01/2023	Evening Meeting (6-9pm): Post SABCS CDK4-6 data update, Park House Hotel Cardiff	Chairing meeting	Honorarium - £720	Own Time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	17/01/2023	Accepted
10/11/2022	Dr Simon Waters	Consultant	Velindre Cancer Service	Gilead Sciences Ltd	09/11/2022	Advisory on TNBC educational meetings and programmes	Advisory Board meeting	Honorarium - £660	Own Time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	09/11/2022	Accepted

Appendix 1 – Gifts, Sponsorship, Hospitality and Honoraria Register (Additional Entries: 04/10/2022 – 18/04/2023)

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
08/11/2022	Dr. John Staffurth	Consultant	Velindre Cancer Service	Johnson & Johnson Sdn Bhd, Selangor Darul Ehsan, Malaysia	25/11/2022 & 26/11/2022	Malaysian Urological Conference 2022	Travel to, within and back from Malaysia, accommodation in Malaysia, food whilst in Malaysia, Honorarium to reflect hours worked, with three lectures being given.	Travel: £3,000 Accommodation: £600 Meals/Refreshments: £100 Honorarium: £1,500	Work done in own time; international travel so travel, accommodation and food covered.	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	07/11/2022	Accepted
08/11/2022	Dr. John Staffurth	Consultant	Velindre Cancer Service	Amgen Limited 240 Science Park Milton Road Cambridge CB4 0WD United Kingdom	25/11/2022	Advisory board - virtual	Advisory board for AMGEN	Honorarium: £1,625	Work done in own time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	07/11/2022	Accepted
08/11/2022	Dr. John Staffurth	Consultant	Velindre Cancer Service	Accord-UK Limited, Whiddon Valley, Barnstaple, Devon, EX32 BNS, United Kingdom	27/10/2022	Advisory board - London	Advisory board for ACCORD	Travel: £202.70 Honorarium: £1,250	Work done in own time	Honorarium to reflect hours worked	Eve Gallop-Evans, Clinical Director	07/11/2022	Accepted

Appendix 2 – Trust Declarations of Interest Register (*via established Annual Review process*)

DESIGNATION	Name	Date Received	Division	Details
Trust Chair	Professor Donna Mead	28/01/2023	Corporate	Directorships: Personal - Director Afan Lodge Ltd Other Positions of Authority: Personal - Fellow Royal College of Nursing, 7 years and member of RCN for 45 years (Non-remunerated) Fellow Learned Society of Wales, 2 years (Non-remunerated) Fellow Swansea University, 4 years (Non-remunerated) Emeritus Professor University of South Wales, 6 years and emplyee for 18 years (Non-remunerated) Honorary Professor Cardiff University, 6 years (Non-remunerated) Expert advisor Wales Committee Royal College of nursing Foundation, 5 years (Non-remunerated) Member of the external advisory board to the Welcome Funded GW4-CAT PhD Programme for Health Prfoessionals, 1 year Health and Care Research Wales: member of advisory group, January 2023 (Non-remunerated) Spouse / Partner or other Relationship Specific to a Contract of Series of Contracts: Son employed by Capita Any Other Interest: Personal - President of Glynneath Division St John Cymru (Wales), 2 years Non-remunerated
Vice Chair	Stephen Harries	27/01/2023	Corporate	• Former Trustee of City Hospice until 5 September 2019. Remains a "member" of the Company, which is subject to the payment of a small annual subscription fee • Independent Member of the Welsh Government's Economy, Treasury and Constitution Group Audit and Risk Assurance Committee (ARAC). The role requires a maximum commitment of 6 days per annum. Trained as Senior Investigating Officer to undertake investigation activity for WG in this regard.
Independent Member	Martin Veale	02/02/2023	Corporate	Directorships: Spouse is a self-employed anatomical embroiderer Board Memberships • Sport Wales 2018- • Pen y Cymoedd Windfarm Community Fund (charity), Chair 2019- Audit Committee (lay) memberships • Welsh Government, Health and Social Services Directorate 2019- • Merthyr Tydfil County Borough Council, Chair 2022- • Pembrokeshire County Council 2017- • Blaenau Gwent County Borough Council 2020- • Monmouthshire County Council 2022- • South Wales Police 2021- • Hafod (Housing Association & Care Homes) 2020- • ACAS 2023- Standard Committee (lay) memberships • Mid and West Wales Fire Authority, Chair 2021- • Merthyr Tydfil County Borough Council 2019- • Brecon Beacons National Park Authority 2021- Education & Inclusion Committee (lay) memberships • Rhondda Cynon Taf CBC 2022- Voluntary • Justice of the Peace, Mid Wales Bench 2016-

DESIGNATION	Name	Date Received	Division	Details
				• Coleg Gwent, Governor 2015- • Hawthorn High School, Pontypridd, Governor 2019- • New 3-16 school at Hawthorn, Pontypridd, Governor 2021- As of 1 March 2023 member of the Audit Committee at ACAS. This is a very occasional role which attracts a daily fee. Any Other Interest: Personal - Fellow of the Chartered Institute of Public Finance & Accountancy Member of the Institute of Internal Auditors Alumni of University of South Wales Alumni of Birmingham City University Alumni of University of East London Member of Ebbw Vale RFC
Independent Member	Gareth Jones	13/03/2023	Corporate	• Senior Counsel (Previously Partner) - Womble Bond Dickinson UK LLP. My firm and I personally advise the Department of Health and Social Care on various arrangements relating to COVID response. My firm has acted for John Sisk & Son Limited which is named in one of the Consortia – PQQ for the nVCC. I do not have any dealings with that client. In addition, we work regularly with other consultants, such as Ove Arup, on behalf of other clients - 13 Years - Salary and Profit Share • Director - Dentrain Limited - 19 Years - Dormant Company. • Spouse/Partner is a Director at Gill Jones Consulting Limited - 2 Years -Trading Company • Interest in Dentrain Limited - 19 years as a 50% shareholder. • Spouse/Partner has an interest in Gill Jones Consulting Limited - 2 years - 100% Shareholder • Spouse Partner is a Trustee of National Examining Board for Dental Nurses - 2 years - honorary Trustee • General Dental Council - Education Associate and Fitness to Practice Panel member • Lay member of Policy and Standards Committee for Institute of Osteopathy • Registrar for UK Public Health Register
Independent Member	Hilary Jones	17/03/2023	Corporate	Chief Executive of Bro Myrddin Housing Association – 12 years – Salary • Member of West Wales Regional Partnership Board - voluntary • Director of Wales Young Farmers Club
Independent Member	Professor Andrew Westwell	30/01/2023	Corporate	• Scientific Advisory Board member for Prostate Cancer UK (review and decisions on competitive grant applications) - 2017 - present (Non-remunerated)
Independent Member	Vicky Morris	26/01/2023	Corporate	• Local Authority School Governor- St Mary's RC Primary School, Newtown, Powys - February 2022 to date. • Non-executive member role with Herefordshire and Worcestershire Integrated Care System as Chair of their Quality, Resource and Delivery Committee and member of their Audit Committee, Strategic Commissioning Committee and Remuneration Committee.
Chief Executive Officer	Steve Ham	29/01/2023	Corporate	Nil interests declared

DESIGNATION	Name	Date Received	Division	Details
Executive Medical Director	Dr. Jacinta Abraham	31/01/2023	Corporate	Personal / Departmental Sponsorship: Attending a Medical Governance Advisory Board Committee for Sciensu, 2-3 times per year (11/02/22-10/02/23) - Honorarium will be received for hours of work which will be performed during annual leave. As part of role as Lead Executive and budget holder for Research Development and Innovation (RD&I), receives, on behalf of the Trust a number of external grants from Commercial & Academic Partnerships which are for specific projects previously agreed within the RD&I Sub-Committee.
Executive Director of Nursing, AHPs and Health Science	Nicola Williams	26/01/2023	Corporate	Nil interests declared
Executive Director of Finance	Matthew Bunce	03/02/2023	Corporate	Nil interests declared
Executive Director of Organisational Development & Workforce	Sarah Morley	04/04/2023	Corporate	Joint President and Trustee of Healthcare People Management Association (01/04/2023 for three years) - No financial reward or benefit in kind. Will be in receipt of expenses.
Chief Operating Officer	Cath O'Brien	22/03/2023	Corporate	Director - Life Sciences Hub Wales. Since April 2018. May be required to attend events representing the Hub with associated hospitality and travel expenses. Partner is Company Director of CTX-Cyf - Since October 2018.
Director of Strategic Transformation, Planning & Digital	Carl James	27/01/2023	Corporate	Nil interests declared
Director of Corporate Governance & Chief of Staff	Lauren Fear	30/01/2023	Corporate	Nil Interests Declared
Head of Digital Delivery	David Mason-Hawes	29/01/2023	Corporate	Nil Interests Declared
Deputy Director of Organisational Development & Workforce	Susan Tomas	27/01/2023	Corporate	Other Positions of Authority: Personal - Appointed as a Magistrate (JP) May 2022
Deputy Director of Finance	Chris Moreton	06/02/2023	Corporate	Trustee and Director: Cynnal Cymru – Sustain Wales - Nov-21 to current - No Financial Transactions or Benefits in Kind

DESIGNATION	Name	Date Received	Division	Details
Head of Financial Operations	Claire Bowden	31/01/2023	Corporate	Nil Interests Declared
**Interim Deputy Director of Nursing* **Since left the Trust to assume new role*	Nigel Downes	20/03/2023	Corporate	Nil interests declared
Director of Welsh Blood Service	Alan Prosser	31/01/2023	Welsh Blood Service	Nil Interests Declared.
**Medical Director – WBS* **Since Retired*	Janet Birchall	30/01/2023	Welsh Blood Service	Nil Interests Declared
Interim Head of Operations and Service Delivery	Rachel Hennessey	27/01/2023	Welsh Blood Service	Nil Interests Declared
Interim Director of Velindre Cancer Service	Paul Wilkins	20/03/2023	Velindre Cancer Service	Nil Interests Declared
Clinical Director of Velindre Cancer Service	Eve Gallop-Evans	26/01/2023	Velindre Cancer Service	Nil Interests Declared
Head of Patient Engagement	Lisa Miller	30/01/2023	Velindre Cancer Service	Nil Interests Declared
Head of Nursing	Vivienne Cooper	29/01/2023	Velindre Cancer Service	Nil Interests Declared
Chief Pharmacist	Bethan Tranter	19/03//2023	Velindre Cancer Service	Interest in Companies and Securities: Husband is recent former owner of Crest Ceilings and Partitions, currently works on a consultancy basis for the business - Over 30 Years Personal or Departmental Sponsorship: Lily Pharma – departmental member undertakes honorarium work, payment for which is submitted to VCC. IMS health/ IQsaraghsaraVIA purchasing
Deputy Director of Procurement	Claire Salisbury	16/03/2023	NWSSP	Nil Interests Declared
Head of Procurement	Christine Thorne	16/03/2023	NWSSP	Nil Interests Declared

DESIGNATION	Name	Date Received	Division	Details
Managing Director and Accountable Officer	Neil Frow	16/03/2023	NWSSP	Spouse is employed Cwm Taf Morgannwg University Local Health Board. Observer at Life Science Hub Board – Attend Board Meetings – Non Paid.
Director of Health Technology Wales	Susan Myles	20/03/2023	HTW	Nil Interests Declared

Clinical Audit (Velindre Cancer Centre)

Final Internal Audit Report

January 2023

Velindre University NHS Trust

Contents

Review reference:	VT-2223-10
Report status:	Final
Fieldwork commencement:	21st November 2022
Fieldwork completion:	7th December 2022
Draft report issued:	23rd December 2022
Debrief meeting:	6th December 2022
Management response received:	24th January 2023
Final report issued:	26th January 2023
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Laura Howells, Principal Auditor
Executive sign-off:	Jacinta Abraham, Medical Director
Distribution:	Nicola Hughes, Acting Medical Directorate Manager Sara Walters, Clinical Audit Manager Catherine Pembroke, Oncology Consultant (Medical Clinical Audit Lead) Zoe Gibson, Head of Nursing, Welsh Blood Service Peter Richardson, Head of Quality Assurance, Welsh Blood Service Dr. Edwin Massey, Deputy Medical Director, Welsh Blood Service Nicola Williams, Director of Nursing
Committee:	Audit Committee Quality, Safety & Performance Committee

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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Velindre University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

To provide assurance that Velindre University NHS Trust (the Trust) has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services.

Overview

The Trust has an approved clinical audit approach. The Trust-wide Clinical Audit Plan incorporates national clinical audits and the local clinical audit programmes for each division.

Mechanisms are in place within Velindre Cancer Centre[1] (VCC) to monitor progress against its local Clinical Audit Programme, and implementation of actions, and to disseminate learning. We identified three medium priority recommendations to enhance these mechanisms.

Other recommendations / advisory points are detailed within section 2.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[2]

	Assurance objectives	Assurance
1	Clinical Audit Strategy / approach	Reasonable
2	Clinical Audit Plan[1]	Reasonable
3	Clinical audit action plans[1]	Reasonable
4	Clinical audit action monitoring, implementation and benefits realisation[1]	Reasonable
5	Learning from clinical audit and triangulation with other quality governance mechanisms[1]	Reasonable

Key recommendations

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1.1	Developing SMART clinical audit actions	3	Operation	Medium
1.2	Independent verification of action implementation	4	Design	Medium
4.1	Ensuring robustness of SST meeting minutes	2,4,5	Operation	Medium

[1] Due to the limitation of scope identified in paragraph 1.5, our work under these objectives focused on clinical audit within VCC only. We were unable to undertake detailed testing on Welsh Blood Service (WBS) clinical audit activities.

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

1. Introduction

1.1 A review of Clinical Audit was completed in line with the 2022/23 internal audit plan. The review sought to provide Velindre University NHS Trust (the Trust) with assurance that there are effective processes in place to manage local and national clinical audit plans.

1.2 Over the previous few years, the Trust has developed its clinical audit activities, moving towards a Trust-wide approach. The annual Clinical Audit Plan was disrupted during the Covid-19 pandemic to release clinical time to focus on care / treatment delivery and to allow for a Covid-focused clinical audit programme to be undertaken.

Associated risks

1.3 The key risk considered during this review was poor patient / donor experience or patient / donor harm resulting from:

- poor clinical audit governance and failure to act on the results of clinical audit;
- lack of robust clinical audit planning leading to inability to identify areas where practice needs to be improved; and
- inability to identify and mitigate some areas of clinical risk.

Limitations of scope

1.4 The WBS quality management system, as set out in its Quality Manual and supporting documents (i.e., non-clinical audit assurance mechanisms) was not in scope for this review.

1.5 Additionally, due to unplanned absence during the audit (see paragraph 2.44), we were unable to undertake the planned testing of clinical audit processes within WBS. The Division forms a small part of the Trust's overall clinical audit activities and has only recently started completing clinical audits. Therefore, the WBS function / activities are still in the early stages of development. We were able to obtain an overview of the Division's governance structures before the absence. This is detailed in paragraph 2.44.

1.6 We recommend that the Trust considers the findings of this review for application within WBS to ensure consistency between the divisions.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	1	3	4
Operating Effectiveness	-	2	-	2
Total	-	3	3	6

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

Audit objective 1: There is an approved clinical audit strategy / approach and clinical risk register in place

2.3 The clinical audit approach is documented within the Trust Clinical Audit Plan (the Plan, see audit objective 2).

2.4 Clinical risks are included on the Trust's Risk Register. Review of the register confirmed clinical risks were present and we identified instances where clinical audit was specifically mentioned to be used to help mitigate certain risks.

Best practice

2.5 We were informed that the Plan is developed using the Healthcare Quality Improvement Partnership's (HQIP) best practice guidance, 'Clinical Audit: A simple guide for NHS Boards & Partners'.

2.6 We undertook a high-level review of the Trust's clinical audit approach (design only) against this best practice guidance. The results are summarised below in figure 1, with further detail set out in Appendix B.

2.7 Except for the need to ensure clinical audit actions are SMART (**matter arising 1**[3]), no significant matters were identified in this review. The Trust's Quality & Safety Framework Improvement Plan will likely address most of the areas where the Trust is not yet fully following best practice. **Matter arising 2**.

2.8 In short, whilst the Trust is still on a journey to have fully robust clinical audit activities, it is making good strides and can have assurance that it is on the right path.

[3] This matter arising does not impact the assurance rating for audit objective 1. Its impact is considered in audit objective 3.

Figure 1: Comparison of the Trust's clinical audit approach against HQIP best practice

Best practice	Status	Best practice	Status
Clinical audit as a broader quality improvement tool	T	Agreeing what constitutes unacceptable variation in results compared to evidence-based standards, etc	
Considering the full range of quality improvement tools for appropriateness	V	Clinical audits cross care boundaries and encompass the whole patient pathway	V
Strategy includes national and local priorities and resource requirements	T	Clear strategy for patient and stakeholder engagement throughout the clinical audit cycle.	V
Consideration of timescales and resources for each clinical audit	V	Sharing clinical audit results with other providers, commissioners, regional networks, etc	V
Rolling clinical audit programme focused on outcome improvements	V	Education and training in clinical audit beyond the clinical audit team	

Status key:

	Approach in line with best practice		Approach partly in line with best practice		Approach not in line with best practice		Out of scope, no review undertaken
T	Whole Trust consideration	V	VCC consideration only due to limitation of scope (paragraph 1.5)				

Clinical audit function

2.9 The Trust's Medical Director is responsible for clinical audit. Within VCC, clinical audit is within the remit of the Medical Directorate. This is consistent with other NHS Wales organisations where we have recently undertaken clinical audit reviews.

2.10 All staff interviewed during our internal audit were content with the current structure for clinical audit within VCC.

2.11 The Trust does not currently have a centralised clinical audit team, so there is a potential risk of inconsistency in approach and inefficient or ineffective triangulation of clinical audit findings. Additionally, there has been resource challenges within the divisional clinical audit teams (paragraphs 2.27-2.28, 2.32, 2.40 and 2.44), highlighting the need for a more resilient approach. The Trust is taking action to address this. **Matter arising 3**.

Conclusion:

2.12 The Trust has a clinical audit approach and clinical risks are managed through the Trust Risk Register. We identified two low priority recommendations relating to best practice and considering a centralised clinical audit team. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 2: An annual clinical audit plan is developed, approved and monitored by appropriate forums. The plan includes applicable audits from the NHS Wales National Clinical Audit and Outcome Review Plan, particularly National Cancer Audits Error! Bookmark not defined.

Development and approval of the Clinical Audit Plan

2.13 The VCC Clinical Audit Programme (the Programme) is predominantly made up of key indicators of practice, NICE guidelines, patient experience, local concerns and

national audits. It is developed in collaboration with the VCC Site Specific Teams (SSTs), directorates and the Division's Quality & Safety Team.

2.14 The Division's Clinical Audit Manager keeps the Programme under continuous review. It is a live document which can be added to throughout the year. Where audits are not concluded at year end, these are rolled over to the next year's Programme.

2.15 The SSTs must complete a proposal form prior to the audit commencing. This form must be authorised by the clinical lead and director. This form outlines considerations including the audit scope, resources, timescales and reason for the audit. We have identified best practice which could enhance this process. **Matter arising 2**.

2.16 Relevant sections of the Programme are discussed and agreed by each SST.

2.17 Directorates receive the final Programme. The VCC Quality and Safety Management Group (QSMG) approves the Programme, which is then sent to the Division's Senior Leadership Team (SLT) for noting.

2.18 The VCC Programme is combined with the WBS Programme to form the annual Trust Clinical Audit Plan.

2.19 The overarching Trust Plan is approved by the Public Quality, Safety & Performance Committee (QSPC). The 2022/23 Plan was approved in July 2022.

National clinical audit

2.20 VCC participates in all appropriate national audits within the NHS Wales National Clinical Audit and Outcome Review Plan.

2.21 The Wales Cancer Network (WCN) is responsible for completing national cancer audits. VCC contributes data for the national audits via the WCN as required.

2.22 We were informed by the Medical Director that she had not been notified of any VCC specific improvements resulting from the national cancer audits, but that she would be informed by email from the WCN should any arise.

Monitoring progress against the VCC Clinical Audit Programme

2.23 The Clinical Audit Manager has a standing agenda item on each monthly SST meeting in which progress against the Division's Programme for that area should be discussed.

2.24 However, our review of a sample of SST minutes highlighted that there is variation in whether the minutes robustly evidence these discussions. **Matter arising 4**.

Conclusion:

2.25 The Trust has an approved, Trust-wide Clinical Audit Plan and VCC participates in the national cancer audits. We identified a medium priority recommendation relating to the robustness of SST minutes and a low priority finding relating to best practice. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 3: SMART action / improvement plans are developed in response to clinical audits undertaken Error! Bookmark not defined.

2.26 The VCC Clinical Audit Manager maintains a combined action plan (spreadsheet) for all SSTs that identifies actions arising from clinical audits. The action plan is monitored by the Division's Clinical Audit Team, and the team consists of two full time and two part time members of staff.

2.27 Due to sickness absence within the VCC Clinical Audit Team, the Clinical Audit Manager has been unable to keep the action plan up to date.

2.28 The VCC Acting Medical Directorate Manager informed us that the Team is now fully resourced, and that the Division will be shortly addressing areas impacted by the sickness absence. **Matter arising 3**.

2.29 Through review of the VCC clinical audit action plan, we identified that the actions are often not SMART, but instead are more of a commentary of what happened during the audit. **Matter arising 1.**

2.30 We understand that the implementation of AMaT (see paragraph 2.38) will assist in resolving the above two points, as Clinical Leads will be responsible for inputting and updating clinical audit actions, and the system templates / fields will support standardisation of actions in a SMART format.

Conclusion:

2.31 We have raised a medium priority recommendation around timely updates to the action plan with SMART objectives and a low priority recommendation relating to potential enhancements to resource for clinical audit. Therefore, we have given this area **reasonable assurance**.

Audit objective 4: Results of clinical audits undertaken (including action / improvement plans) are reported to appropriate forums. Actions are monitored to ensure implementation and benefit realisation Error! Bookmark not defined.

Reporting results and monitoring action implementation

2.32 Each VCC clinical audit has a Clinical Lead. A member of the Division's Clinical Audit Team should periodically follow up on clinical audit results / outcomes with the relevant Clinical Lead and via SST meetings. However, due to sickness absence within the Division's Clinical Audit Team, the Clinical Audit Manager attends all monthly SST meetings but further follow up is limited. **Matters arising 1 and 3**.

2.33 Within the clinical audit standing agenda item on each monthly SST meeting, completed clinical audits should be discussed, alongside monitoring the implementation of clinical audit actions. However, our review of a sample of SST minutes highlighted that there is variation in whether the minutes robustly evidence these discussions. **Matter arising 4**.

Oversight of actions arising from cross-SST clinical audits

2.34 Currently there is no designated forum that provides overarching oversight of actions resulting from clinical audits that span multiple SST's. We were informed that this will be reviewed in line with the quality hub structure.

2.35 This is an issue the Division has already identified and flagged with the VCC SLT. We understand this matter has been passed to the Trust's Interim Clinical Transformation Lead for further consideration.

2.36 We were also informed that clinical audit governance and reporting mechanisms are being considered as part of the Trust's wider review of quality and safety governance and reporting within the Quality & Safety Implementation Plan. We understand that there is representation from clinical audit in the newly formed Trust Integrated Quality & Safety Group, which is responsible for this process. **Matter arising 5**.

Independent verification of action implementation and benefit realisation

2.37 The action plan does not identify audits that require re-auditing, e.g., because of identified poor performance, although we note that the VCC Programme includes and identifies re-audits. There is also no process to independently verify that actions have been implemented and benefits have been realised where re-audits are not planned. **Matter arising 1**.

Clinical audit management and tracking software

2.38 The Trust has procured AMaT, a web-based Audit Management and Tracking tool. AMaT provides control over audit activity and gives real-time insight and reporting for clinicians, wards, audit departments and healthcare trusts. AMaT is currently being piloted within VCC and has been funded for a two-year trial period. It is being reviewed by the VCC Senior Leadership Team to ensure value for money is being achieved prior to further roll-out.

Conclusion:

2.39 Whilst mechanisms for monitoring action implementation / benefit realisation exist, we identified three medium priority recommendations concerning verification of implementation, the robustness of SST minutes and oversight for cross-SST clinical audits. We also identified one low priority recommendation. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 5: Learning from clinical audit is disseminated across the Trust and triangulated with learning other quality governance mechanisms as appropriate[Error! Bookmark not defined.]

2.40 Learning from clinical audit is distributed across VCC in several ways:

1. SST meetings: Within the clinical audit standing agenda item on each monthly SST meeting, learning should be discussed. However, our review of a sample

of SST minutes highlighted that there is variation in whether the minutes robustly evidence these discussions. **Matter arising 4**.

2. Virtual clinical audit event: Virtual events have been developed and replace the clinical effectiveness presentation events that were halted due to Covid. These virtual events provide SSTs with the opportunity to present results from clinical audits and discuss lessons learnt. Two events took place last year to present results from the SSC projects and the team are working to establish a bi-annual quality learning event in addition to the SSC presentations. **Matter arising 3**.
3. Clinical Audit Highlight reports: The VCC QSMG receives these reports which include feedback from audits and key issues identified.

2.41 The Trust is developing Quality Hubs (Trust-wide and divisional) as part of its new Quality & Safety Framework. The plan is that this will support improved triangulation of all quality improvement and assurance activities by formalising the process and providing a forum for triangulation to take place.

2.42 During our fieldwork for the 2022/23 Patient & Donor Experience internal audit (ref 2223-11), we saw evidence that clinical audit is being informally triangulated with other quality and safety mechanisms, such as patient / donor experience and concerns / complaints.

Conclusion:

2.43 The Trust has several channels to disseminate lessons learnt. Planned development of the Trust's quality governance mechanisms will further enhance this and triangulation with other quality governance mechanisms. We have raised one medium priority recommendation concerning the robustness of SST minutes and one low priority recommendation. Therefore, we have provided **reasonable assurance** over this audit objective.

Welsh Blood Service

2.44 In depth testing within this area was not completed due to unplanned sickness absence in the WBS clinical audit team (the role is undertaken by a senior nurse as a small part of a broader operational role) during our fieldwork. The Trust had recognised this single point of failure prior to our internal audit review and had very recently taken action to improve resilience; the Deputy Medical Director for WBS will oversee the Division's clinical audit activities going forward. **Matter arising 3**.

2.45 Whilst we were unable to undertake in-depth testing at WBS in line with the agreed internal audit scope, we were able to identify that:

- the Division has an annual Clinical Audit Programme which is included within the overall annual Trust Plan; and
- per the approach documented in the Trust Plan, progress on the WBS Programme should be discussed at the Division's Regulatory Assurance

Governance Group (RAGG); however, we found that there is minimal evidence of this taking place. **Matter arising 5**.

Conclusion:

2.46 Given the given the limitations to the testing we were able to undertake in this area, we have not provided an assurance rating.

Appendix A: Management Action Plan

Matter arising 1: Clinical Audit Actions	Impact
Action plan: Due to sickness absence, the VCC Clinical Audit Manager has been unable to update the clinical audit action plan in a timely manner. The action plan was not up to date at the time of our audit. **SMART actions:** We identified that actions arising from clinical audits are often not SMART, but instead are more of a commentary of what happened during the audit. **Informal follow up on actions:** Due to sickness absence, the Clinical Audit Manager attends all monthly SST meetings but further follow up is limited. **Formal follow up on actions:** Currently the action plan does not identify audits that require re-auditing, although we note that the Clinical Audit Plan includes and identifies re-audits. There is also no process to independently verify that actions have been implemented and benefits have been realised where re-audits are not planned.	Potential risk of: • actions not achievable, effective or implemented; and • poor patient / donor experience or patient / donor harm.

Recommendations	Priority
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 (Operation)
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.	
c. Guidance and training on developing SMART actions should be provided to Clinical Leads.	
1.2 a. The clinical audit action plan should identify whether a re-audit is required, along with the reason and timescales therefor.	Medium (Design)
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.	

	Management response	Target Date	Responsible Officer
1.1	A. 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.	June 2023	Medical Directorate Manager
	B. 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.	April 2023	Clinical Audit Manager
	C. Produce a SMART action training guide for all audit leads to follow.	April 2023	Clinical Audit Manager
1.2	A. Where re-audit is required, this is included in the action plan, a section will be added to document the reason for re-audit. Timescales are usually recorded. Not all audits require re-audit this is identified via the recommendation or documented on the proforma. Ensure where re-audits are required that all documentation reflects this clearly.	March 2023	Clinical Audit Manager
	B. Formalise the current process to evidence actions and benefits have been undertaken or realised.	June 2023	Clinical Audit Manager

Matter arising 2: Clinical Audit Best Practice	Impact
Our review of HQIP best practice for clinical audit identified several areas where the Trust could enhance its clinical audit activities. We have outlined below those not raised via other matters arising in this report: • using clinical audit in strategic management as part of the broader quality improvement programme; • only choosing clinical audit when it is the best methodology to assess the issue at hand; • consider local clinical audits (i.e., beyond the National Cancer Audits) that cross organisational boundaries and encompass the whole patient pathway; and • engaging patients, donors & stakeholders throughout the full clinical audit cycle, including annual planning and audit fieldwork. The following best practice areas were out of scope for this review, but are included here for completeness: • agreeing what constitutes unacceptable variation in clinical audit results compared to available best practice; and • providing education and training in clinical audit beyond the clinical audit team, inclusion of clinical audit in objectives and appraisals. Further details are included in Appendix B.	Potential risk of: • inability to maximise the effectiveness of clinical audit activities; and • ineffective clinical audit activity that does not provide value for money.

Recommendations	Priority
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 (Design)

Management response	Target Date	Responsible Officer
2.1 All best practice identified in this report to be reviewed and applied where possible to improve the effectiveness of clinical audits.	July 2023	Medical Clinical Audit Lead (Oncology Consultant)

Matter arising 3: Centralised Clinical Audit Function	Impact
The Trust does not currently have a centralised clinical audit team, which could potentially lead to silo working. Additionally, there have been resource challenges within the divisional clinical audit teams due to sickness absence. Specifically, this has impacted: • maintenance of the VCC clinical audit action plan (paragraphs 2.27-2.28); • informal follow up of implementation of actions within VCC (paragraph 2.32); • rolling out further VCC virtual clinical audit events (paragraph 2.40); and • our ability to undertake detailed testing of WBS clinical audit activities (paragraph 2.44). The Trust is taking action to improve resilience within the divisional clinical audit teams.	Potential risk of: • inconsistency in clinical audit approach; • inefficient or ineffective triangulation of clinical audit findings; • lack of resilience potentially leading to ineffective clinical audit; and • poor patient / donor experience or patient / donor harm.

Recommendations	Priority
3.1 The Trust should consider joining the divisional clinical audit teams into a centralised Trust clinical audit team.	Low (Design)

Management response	Target Date	Responsible Officer
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.	July 2023	Medical Director

Matter arising 4: Robustness of SST Minutes	Impact
Our review of a sample of SST minutes highlighted that there is variation in whether scrutiny of clinical audit activity (Programme progress, audit findings, learning, action implementation, etc) is robustly evidenced in the meeting minutes.	Potential risk of: • inability to evidence scrutiny and accountability of clinical audit activities; • lack of progress on clinical audit plan or action implementation not being identified; and • poor patient / donor experience or patient / donor harm.

Recommendations	Priority
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 (Operation)

Management response	Target Date	Responsible Officer
4.1 Annual audit engagement with each SST with robust documented discussion including annual plan, progress, learning and actions.	July 2023	Clinical Audit Manager
Review of SST meetings to establish how discussions are documented with progress of clinical audits.	July 2023	Clinical Audit Manager

Matter arising 5: Clinical Audit Reporting and Oversight Mechanisms	Impact
Velindre Cancer Centre Currently there is no designated forum that provides overarching oversight of actions resulting from clinical audits that span multiple SST's. This will be reviewed in line with the quality hub structure. This is an issue the Division has already identified and flagged with the VCC SLT. We understand this matter has been passed to the Trust's Interim Clinical Transformation Lead for further consideration. We were also informed that clinical audit governance and reporting mechanisms are being considered as part of the Trust's wider review of quality and safety governance and reporting within the Quality & Safety Implementation Plan. We understand that there is representation from clinical audit in the newly formed Trust Integrated Quality & Safety Group, which is responsible for this process. **Welsh Blood Service** The Trust's clinical audit approach (set out in the Trust Clinical Audit Plan) requires that progress on the WBS Clinical Audit Programme be reported to the Division's RAGG meetings. However, we found that there is minimal evidence of this taking place.	Potential risk of: • lack of collaboration between the SSTs resulting in actions not implemented; • trends that affect multiple SSTs going unidentified; and • poor patient / donor experience or patient / donor harm.

Recommendations	Priority
5.1 a. 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'. 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 (Design)

Management response	Target Date	Responsible Officer
5.1 a. 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.	December 2023	Clinical Audit Manager

Management response (continued)	Target Date	Responsible Officer
b. **VCC:** Current process map of the VCC governance and reporting mechanism to be added to the clinical audit intranet page.	May 2023	Clinical Audit Manager
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.	Completed	Deputy Medical Director WBS

Appendix B: Comparison against clinical audit best practice

We reviewed the Trust's clinical audit approach (design only) against the best practice guidance in HQIP's 'Clinical Audit: A simple guide for NHS Boards & Partners'. We have identified within the table where we have been unable to consider the WBS approach due to the limitation of scope (paragraph 1.5).

Status key

Approach in line with best practice	Approach partly in line with best practice	Approach not in line with best practice	Out of scope, no review undertaken

Best practice for robust clinical audit activities	Status	Trust approach
Use clinical audit as a tool in strategic management as part of the broader quality improvement programme; obtain assurance that the strategy for clinical audit is aligned to broader interests and targets that the board needs to address	Trust	The Trust Clinical Audit Plan confirms the audits have been mapped against the Health & Care Standards for Wales and we saw evidence of clinical audit findings being informally triangulated with other quality mechanisms. Improved coordination of quality governance mechanisms and alignment of the mechanisms with the Trust's strategy and goals are among the aims of the Trust's new Quality & Safety Framework and supporting Implementation Plan. **Matter arising 2**.
Consider the full range of quality improvement tools and choose clinical audit if its methodology is best suited to assess the issue at hand and develop an improvement plan	VCC only	VCC Clinical Leads must identify the reason for a clinical audit on the clinical audit proposal form when submitting the audit for inclusion in the VCC Clinical Audit Programme. However, this does not fully address the best practice to consider if clinical audit is the most appropriate mechanism. **Matter arising 2**.
A clinical audit strategy must include a combination of national and local priorities with sufficient resources to complete the cycle for each element of the programme	Trust	The Trust's Clinical Audit Programme includes national and local priorities. However, there are some resource constraints with the divisional clinical audit teams. The Trust is taking action to address this, and we have made a recommendation for further consideration. **Matter arising 3**.
Agree on the timescale and resources required for each clinical audit activity upfront but have a process in place to deal with variations and additional requirements	VCC only	Anticipated timescales and resources are considered on the clinical audit proposal form (note: we reviewed the template form but further testing on the completion of the forms was not within the scope of our internal audit). The timescales are included in the VCC Clinical Audit Programme which is approved by the SSTs.
Operate a rolling clinical audit programme that covers the different stages of individual projects on a continuous basis focused on outcome improvements for each area	VCC only	The Trust's clinical audit activities aim to support outcome improvements. However, we identified that: • clinical audit actions are often not SMART, limiting the effectiveness of monitoring implementation, assessing benefit realisation and achieving outcome improvements (**matter arising 1**); • there is variation in the robustness of SST meeting minutes evidencing monitoring action implementation (**matter arising 4**); • informal follow up on implementing actions has been limited due to sickness absence in the VCC Clinical Audit Team (**matter arising 1**); and • except where a full re-audit is scheduled, there is no process to independently verify that actions have been implemented and benefits realised / outcomes improved (**matter arising 1**).
Ensure the professionalism of clinical audit by agreeing what constitutes unacceptable variation in clinical audit results compared to evidence-based standards, outcomes at similar organisations, or with standards developed within the organisation where national guidelines are not available		Whilst out of scope for this internal audit, we saw evidence of this in practice in the clinical audits sampled as part of our 2021/22 Infection, Prevention & Control internal audit.

Best practice for robust clinical audit activities	Status	Trust approach
Ensure with others that clinical audit crosses care boundaries and encompasses the whole patient pathway	VCC only	VCC participates in national cancer audits via the Wales Cancer Network. We were informed that the Division also undertakes multi-centred audits and cross-site projects. Currently, VCC does not participate in local audits that follow the patient pathway across organisational boundaries. **Matter arising 2**.
Develop a clear strategy to ensure patient and stakeholder engagement at the different stages of the clinical audit cycle, make clinical audit reports patient-friendly and publicly available, and disseminate summaries of results to stakeholders and patients in a variety of ways	VCC only	VCC publicly publishes or shares clinical audit related reports with stakeholders in a variety of ways, including: • Trust Clinical Audit Plan and Annual Report available via public QSPC papers; • pertinent findings from clinical audits are included in the Annual Report; and • for individual audits, results may be shared with relevant health boards where relevant; some projects are published, and others are publicised via posters or abstracts at different conferences. At present, VCC does not engage patients and stakeholders at other stages of the clinical audit cycle, e.g., annual planning, during fieldwork, etc. **Matter arising 2**.
Share clinical audit results with other providers, commissioners, regional clinical networks and local patient networks. Publish outcome statistics and evaluations	VCC only	As noted above, where relevant, VCC clinical audit data is shared with health boards to inform second stage commissioning requests.
Provide sufficient education and training in clinical audit beyond the clinical audit team, ensure that clinical audit is included in objectives and appraisals, and use clinical audit and quality improvement projects as a valuable resource.		N/a

Appendix C: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Clinical Audit

All-Wales Themes Report (April 2018 – January 2023)

April 2023

Velindre University NHS Trust

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

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

Contents

Report status:	Draft
Period covered:	April 2018 to January 2023
Report issued:	6th April 2023
Prepared by:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit
Distribution:	Jacinta Abraham, Medical Director Nicola Williams, Director of Nursing, AHPs & Health Scientists Executive Management Board Integrated Quality & Safety Group
Committee:	Audit Committee Quality, Safety & Performance Committee

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

Acknowledgement

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

Executive Summary

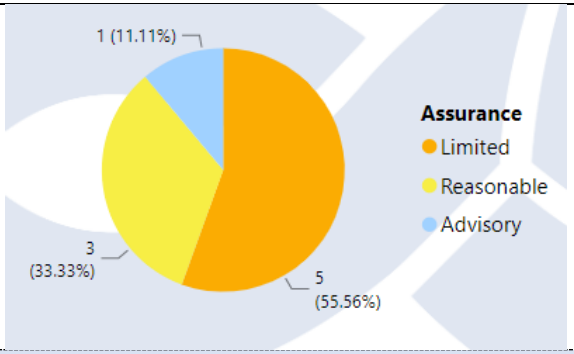
We have analysed the themes arising from recommendations we have made in our nine clinical audit internal audit reports across seven Welsh health bodies over the previous five years. In this report, we identify the resulting learning and good practice alongside benchmarking the Velindre University NHS Trust's (the Trust) position.

Report Assurance Ratings

Trust 2022/23 Rating

Reasonable assurance

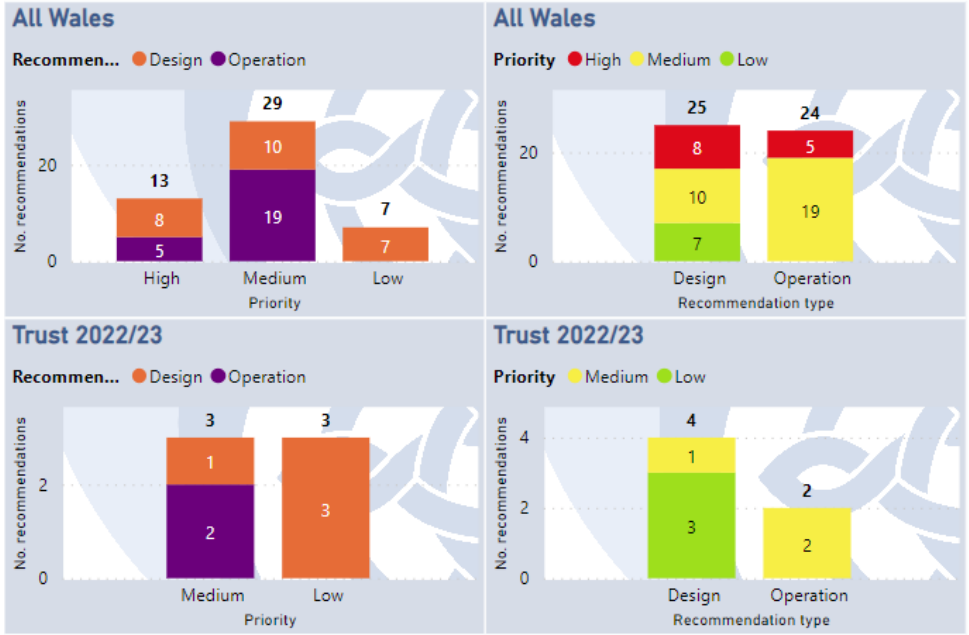
All 2018 – 2023 Clinical Audit Report Ratings[1]



We provided the Trust with a reasonable assurance opinion for its 2022/23 Clinical Audit Internal Audit ('the 2022/23 report'). This compares favourably with the wider NHS Wales picture over the previous five years, where five of the nine reviews undertaken – two of which were follow-ups on prior year limited assurance reports – received a limited assurance opinion.

Over the five-year period, we made 49 separate recommendations – 13 high priority, 29 medium priority and 7 low priority – across the eight assurance reports issued, with an average of 6 recommendations per report. Of the 49 recommendations:

- 25 were control design recommendations, where organisations' controls / processes required improvement; and
- 24 were operating effectiveness recommendations, where organisations' controls / processes were not being appropriately followed.



[1] Includes the Trust's 2022/23 internal audit on clinical audit.

Recommendation Themes[2]

The main themes identified in our reports were:

- **Planning, Delivery & Deadline Management**: ten occurrences across four health bodies. Recommendations relate predominantly to:
  - the need to develop a Clinical Audit Strategy;
  - ensuring local clinical audit plans are in place; and
  - ensuring action tracking is operating effectively.
- **Governance & Risk Management:** ten occurrences across six health bodies. Recommendations include improvements to:
  - local clinical audit governance mechanisms;
  - clinical audit oversight and scrutiny at Board level; and
  - capturing clinical risks identified through clinical audits.

[2] Theme definitions are set out in Appendix B.

High priority recommendations not in top themes

In addition to the key recommendations highlighted within the top two clinical audit recommendation themes, we identified three high priority recommendations within the Finances & Resourcing and Ineffective Controls themes. These related to:

- inadequate resources for monitoring clinical audits within a clinical audit team;
- limitations of systems to effectively monitor clinical audit and outcomes (use of Excel rather than an audit management tool); and
- lack of evidence to support review of wider information (e.g., corporate risk register, incidents, complaints, etc) when developing the clinical audit plan.

Good practice

Key areas of clinical audit good practice identified include:

- approved Clinical Audit Strategies, Plans, Policies and Procedures;
- clinical audit oversight and scrutiny at Board level;
- centralised clinical audit teams; and
- delivery of clinical audit training.

Trust status and key learning

Key recommendations across Welsh health bodies	Trust status (based on our 2022/23 Trust Clinical Audit Internal Audit)
The need to develop and / or approve a Clinical Audit Strategy	The Trust has an approved Clinical Audit Strategy within its Clinical Audit Plan.
Ensuring appropriate local clinical audit plans are in place	Velindre Cancer Centre (VCC) had local clinical audit plans in place.
Ensuring action tracking mechanisms are operating effectively	Also identified in the Trust's 2022/23 Internal Audit report (recommendation 1.1).
The need to improve local clinical audit governance mechanisms	Also identified in the Trust's 2022/23 report (recommendation 5).
Greater Board level oversight and scrutiny of clinical audit	The Trust's Board and Quality, Safety & Performance Committee (QSPC) provide oversight and scrutiny of clinical audit.
Capturing clinical risks identified through clinical audits	Clinical risk is recorded within Datix in general. The Trust may wish to consider this point further.
Inadequate resources for monitoring clinical audits	Considerations also identified in the Trust's 2022/23 Internal Audit report (recommendation 3).
Limitations of systems to effectively monitor clinical audit	The Trust planned to use the AMaT clinical audit software.
Lack of evidence to support review of wider information (e.g., risk register, incidents, etc) when developing the clinical audit plan	These considerations were incorporated into the VCC Clinical Audit Programme.

Key good practice identified across Welsh health bodies	Trust status (based on our 2022/23 Trust Clinical Audit Internal Audit)
Approved Clinical Audit Strategy	
Approved Clinical Audit Plan	
Approved Clinical Audit Policies & Procedures	The Trust may wish to consider whether it has consistent Clinical Audit Policies and Procedures across its divisions.
Board / Committee scrutiny	
Identified Clinical Audit Leads	
Centralised Clinical Audit Team	The Trust does not currently have a centralised clinical audit team. Raised as a consideration in the 2022/23 report (recommendation 3).
Participation in national clinical audit	
Use of clinical audit software	
Use of clinical audit registration forms	The Trust has a template registration form.
Delivery of clinical audit training	The Trust may wish to consider the level of clinical audit training it provides (including training to use AMaT).

Key (based on comparison of key points to the Trust's 2022/23 Internal Audit report):

No comparable matters arising / already in place at the Trust	Good practice for consideration	Similar recommendation already identified in 2022/23 report	New area of concern identified through this report	Not in scope

Introduction

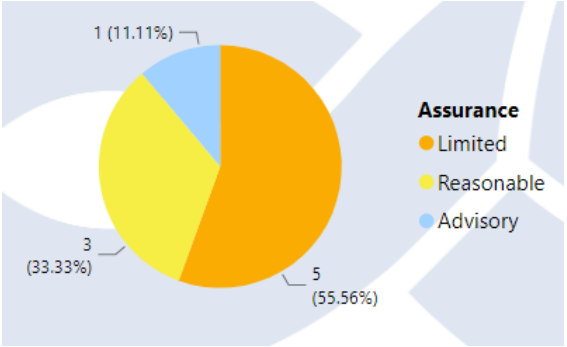
We have undertaken an analysis of the themes arising from recommendations made in our Clinical Audit Internal Audit reports across NHS Wales over the previous five years. During this time, we have undertaken nine Clinical Audit reviews across five Health Boards and two Trusts. The table below provides further detail on the period covered and nature of the reports included in this analysis.

Period covered		April 2018 – January 2023	
Number of reviews[1]		9	
Split as:	Report type	Assurance: 8	Advisory: 1
	Scope of review	Full review: 5	Follow-up: 4
Number of organisations		7	
Split as:	Health Board	5	
	Trust	2	

In this report, we identify the resulting learning and good practice alongside benchmarking the Trust's position.

Note: Recommendations referenced within this report relate to the Trust's 2022/23 Clinical Audit Internal Audit Report. No further recommendations have been made in this report.

All-Wales Overview



All seven health bodies included in our analysis were undertaking clinical audit in some form at the time of their respective reviews, including national, organisation-wide and local audits.

However, five of the nine reports issued – two of which were follow-up reviews on previous limited assurance reports – receiving a limited assurance opinion, i.e., significant matters were identified over the governance, risk management and internal control of clinical audit within those organisations. In total, we identified 13 high priority recommendations over the five-year period.

Key matters arising related to:

- Planning, Delivery & Deadline Management: lack of Clinical Audit Strategy and poor coordination of oversight of clinical audit, particularly at a local level; and

- Governance & Risk Management: improvements required to ensure appropriate oversight and scrutiny of clinical audit at Board, Committee and local levels.

Other high priority recommendations related to:

- a lack of clinical audit policies and procedures;
- non-compliance with policies and procedures, including reporting to Committee level and disseminating learning;
- insufficient clinical audit reporting at Board and local levels;
- inadequate resources for monitoring clinical audits; and
- ineffective controls from limitations of systems to effectively monitor clinical audit and lack of evidence to support considerations in developing clinical audit plans.

Pandemic impact

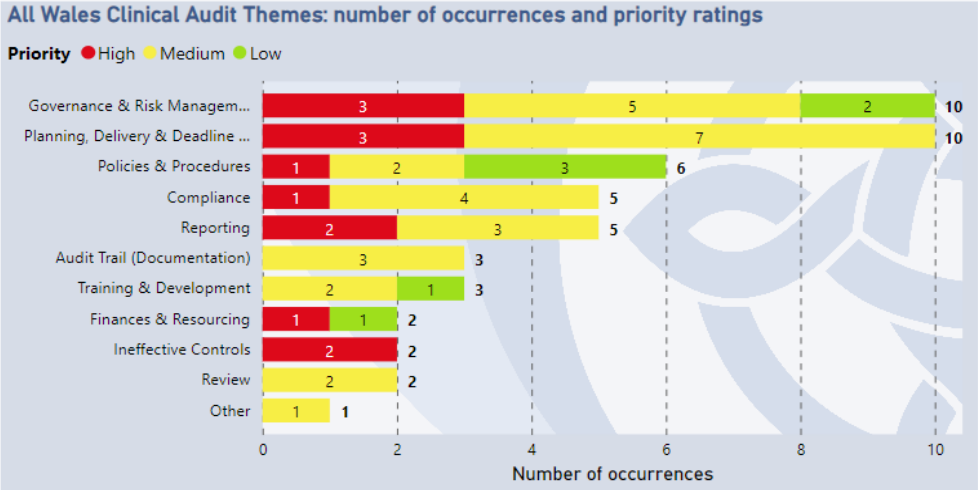
Five of the clinical audit reviews undertaken took place during or shortly after the Covid-19 pandemic. Within the organisations reviewed, clinical audit continued during this time although, understandably, clinical audit activities were impacted.

Common pandemic impacts to clinical audit included:

- delays experienced in approving clinical audit plans;
- clinical audit training paused or reduced;
- meetings where clinical audit would usually be scrutinised being stood down, impacting oversight and scrutiny of clinical audit; and
- delays in planned improvements to clinical audit governance and activities.

During the 2022/23 review, we were informed that the Trust's annual Clinical Audit Plan was disrupted during the pandemic to release clinical time to focus on care / treatment delivery and to allow for a Covid-focused clinical audit programme to be undertaken. At the time of the review, the Trust's clinical audit activities had returned to business as usual.

Clinical Audit Themes Analysis



The top five themes identified across our 2018-2023 clinical audit reports were:

	Theme	Brief Theme Definition*
1	Governance & Risk Management	Inadequate or ineffective governance routes, or lack of understanding thereof.
2	Planning, Delivery & Deadline Management	Poor planning resulting in missed deadlines, non-delivery, overspends or poor-quality work.
3	Policies & Procedures	Inadequate or lack of policies and procedures.
4	Compliance	Non-compliance with policies, procedures, laws, or regulations. Lack of compliance monitoring.
5	Reporting	Inadequate report quality or lack of reporting affecting the ability to provide assurance or support effective decision making.

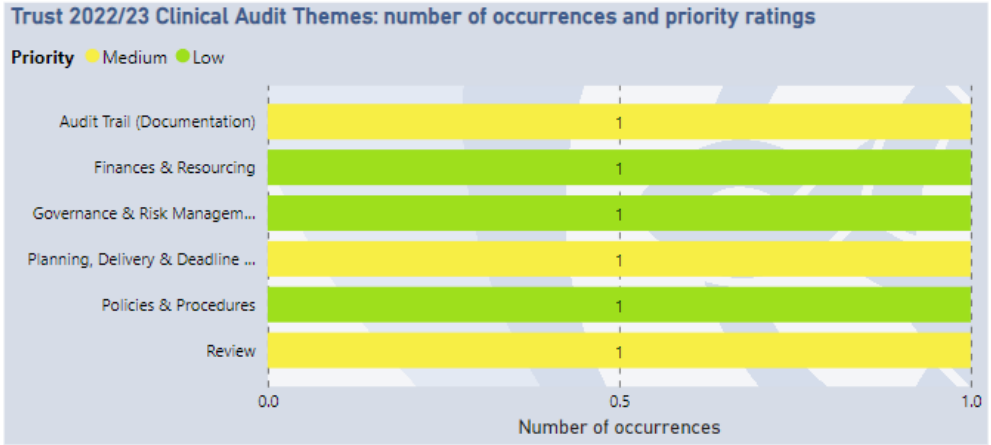
**Full definitions provided in Appendix B.*

Occurrences of the top five themes make up 73% of all theme occurrences (36 of the 49 theme occurrences).

Of the 13 high priority recommendations we made (set out on the previous page), ten (77%) appear within the top five themes.

Further analysis of the recommendations behind the top five themes and learning for the Trust is undertaken later in this report.

Trust Themes



The Trust's 2022/23 report contained six recommendations – three medium priority and three low priority. Six

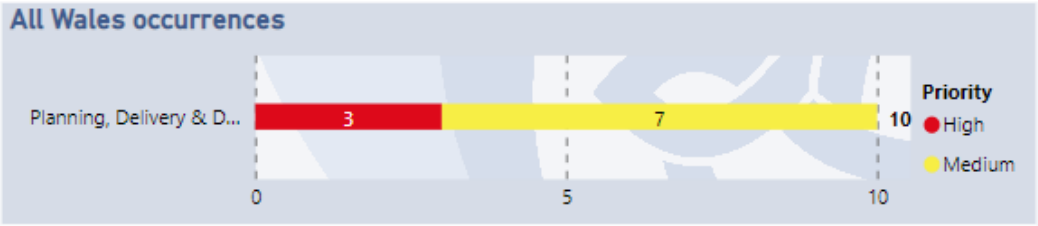
different themes were identified. The full recommendations are set out in the 2022/23 report and are summarised here:

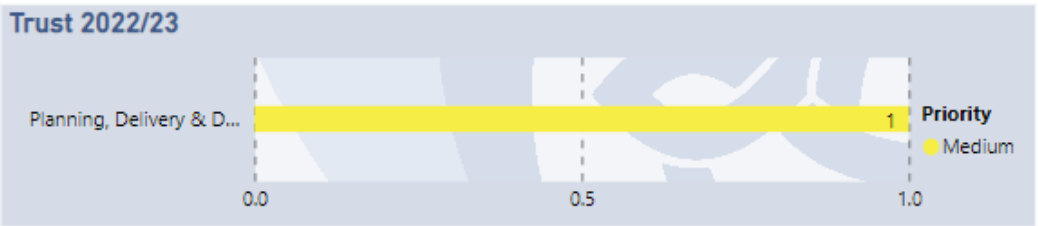
Theme	Priority	In top 5 themes	Ref	Summary of recommendation
Governance & Risk Management	Low	Y	5	Clinical audit reporting and oversight mechanisms could be strengthened at a divisional level.
Planning, Delivery & Deadline Management	Medium	Y	1.1	The Trust's clinical audit action tracker needs to be kept up to date. Actions within the tracker should be SMART.
Policies & Procedures	Low	Y	2	We identified clinical audit best practice for consideration by the Trust as it continues to develop its clinical audit activities.
Review	Medium	N	1.2	Process required to independently verify clinical audit actions have been implemented.
Audit Trail	Medium	N	4	Ensuring meeting minutes at a local level are sufficiently robust to evidence oversight and scrutiny of local clinical audit.
Finances & Resourcing	Low	N	3	Consideration of a centralised Trust clinical audit team.

Learning from top five 2018-2023 clinical audit recommendation themes

Planning, Delivery & Deadline Management

Ten occurrences within five reports across four health bodies, including one within the Trust's 2022/23 report:



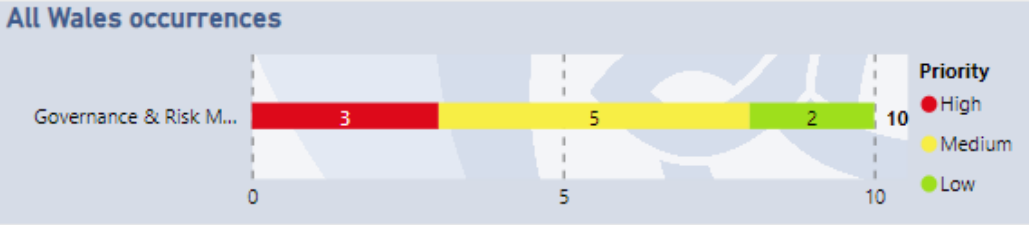


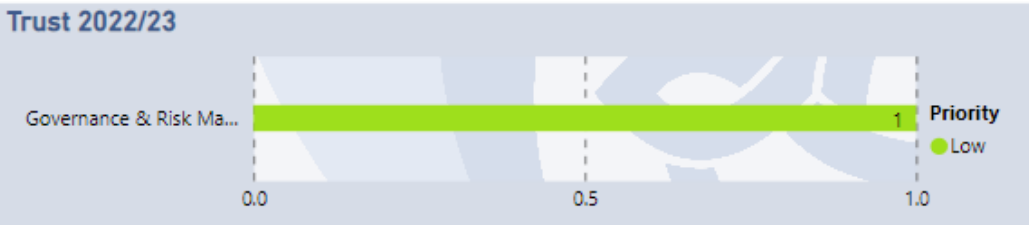
Key Theme Recommendations	Trust position	Comments (based on our 2022/23 Trust Clinical Audit Internal Audit)
The need to develop and / or approve a Clinical Audit Strategy	✓	The Trust has an approved Clinical Audit Strategy / approach within its annual Clinical Audit Plan.
Ensuring appropriate local clinical audit plans are in place	✓	We saw evidence of local clinical audit plans for Velindre Cancer Centre (VCC) during the 2022/23 review
Ensuring action tracking mechanisms are operating effectively	!	The Trust has a clinical audit action tracker. However, due to resource constraints – in part related to absence within the VCC clinical audit team – the tracker was not up to date at the time of our 2022/23 review. We also noted that actions within the tracker were often not SMART (recommendation 1.1).

! Other recommendations included mapping of quality governance mechanisms across clinical / quality risks to demonstrate assurance and controls across key areas and ensuring deadlines for audit completion are clear. The Trust may wish to consider these points further as it continues to develop its clinical audit activities.

Governance & Risk Management

Nine occurrences within six reports across six health bodies, including one within the Trust's 2022/23 report:

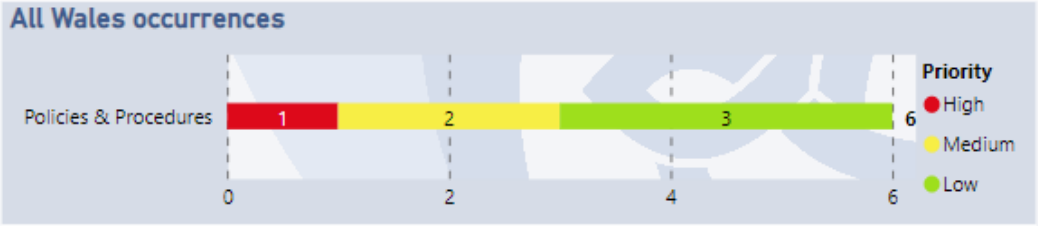


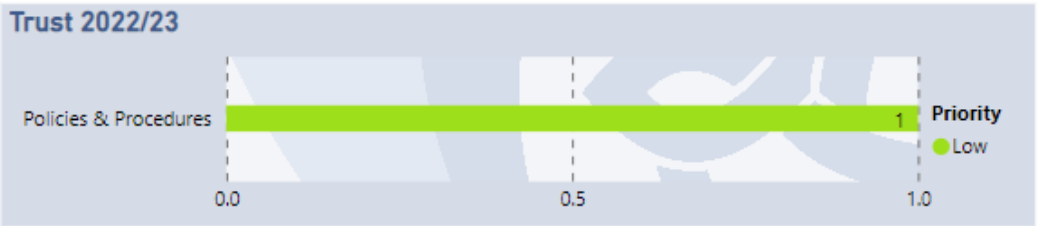


Key Theme Recommendations	Trust position	Comments (based on our 2022/23 Trust Clinical Audit Internal Audit)
The need to improve local clinical audit governance mechanisms	!	We identified that clinical audit reporting and oversight mechanisms could be strengthened at a divisional level. This was raised in the Trust's 2022/23 Clinical Audit Internal Audit report (recommendation 5).
Greater Board/Committee level oversight and scrutiny of clinical audit	✓	The Trust's Clinical Audit Plan and Annual Clinical Audit Report are presented to the QSPC. Going forward, clinical audit will also be reported to QSPC via the Quality Report, which will include triangulation of the Trust's quality governance mechanisms.
Improvements in capturing clinical risks identified through clinical audits	◆ !	We did not specifically look at whether the Trust is capturing clinical risks identified though clinical audits in Datix. However, we did see evidence that clinical risk is recorded within Datix in general. The Trust may wish to consider this point further as it continues to develop its clinical audit activities.

Policies and Procedures

Six occurrences within five reports across five health bodies, including one within the Trust's 2022/23 report:



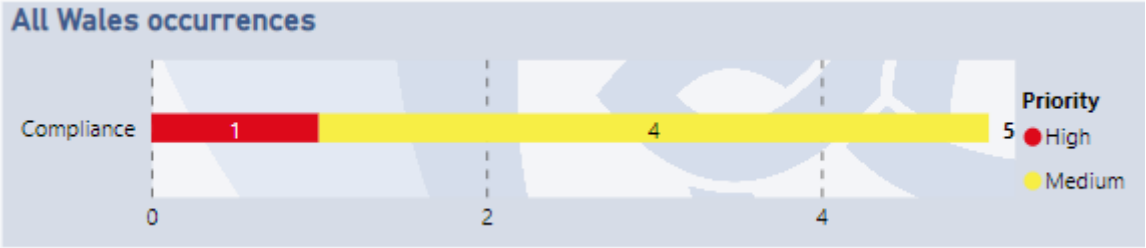


Key Theme Recommendations	Trust position	Comments (based on our 2022/23 Trust Clinical Audit Internal Audit)
The need to develop or review clinical audit policies and procedures	◆	Whilst policies and procedures for carrying out clinical audit were not in scope for our 2022/23 review, we note that the Trust's annual Clinical Audit Plan contained a comprehensive overview of the Trust's approach to clinical audit.

! Other recommendations included ensuring there is an approved definition for the role of Clinical Audit Sponsors and the use of RAG rating for clinical audit actions based upon priority. The Trust may wish to consider these points further as it continues to develop its clinical audit activities.

Compliance

Five occurrences within three reports across three health bodies. No occurrences were noted at the Trust.



Key Theme Recommendations	Trust position	Comments (based on our 2022/23 Trust Clinical Audit Internal Audit)
Improvements needed around the structure for national and organisation-wide clinical audit, including:		
1. bringing these tiers to form an organisation-wide programme;	✓	The Trust Clinical Audit Plan contains all relevant national and local clinical audits.
2. regular reporting to quality and performance committee;	✓	QSPC receives the Clinical Audit Plan and Annual Clinical Audit Report. Clinical audit will also be reported regularly to QSPC via the Quality Report.
3. defining routes to effectively disseminate learning; and	✓	The Trust has routes to disseminate learning, although our report noted this has been impacted by resourcing challenges (recommendation 3).
4. provide assurance over action implementation.	!	The Trust did not have a formal process to independently verify actions have been implemented (recommendation 1.2).

◆ Other recommendations included ensuring clinical audits are registered on a central clinical audit register. Testing this was out of scope for our review at the Trust, although we verified the Trust has a template registration form.

Reporting

Five occurrences within four reports across four health bodies. No occurrences were noted at the Trust.

Key Theme Recommendations	Trust position	Comments (based on our 2022/23 Trust Clinical Audit Internal Audit)
Improved reporting to Board / Committee level in terms of frequency and content	✓	The Trust's Clinical Audit Plan and Annual Clinical Audit Report are presented to the QSPC. Going forward, clinical audit will also be reported to QSPC via the Quality Report, which will include triangulation of the Trust's quality governance mechanisms.
Ensuring consistent and effective reporting of clinical audit at a local level.	!	We identified that clinical audit reporting and oversight mechanisms could be strengthened at a divisional level (recommendation 5).

Learning from other high priority recommendations

In addition to the key recommendations highlighted within the top two clinical audit recommendation themes, we identified three high priority recommendations within the Finances & Resourcing and Ineffective Controls themes.

Other High Priority Recommendations	Trust position	Comments (based on our 2022/23 Trust Clinical Audit Internal Audit)
Finances & Resourcing: the need to ensure appropriate resourcing for clinical audit within clinical audit teams.	!	The Trust did not have a central clinical audit team. We also noted that both divisions had experienced resource challenges due to absences, which led to some of the findings in our report (recommendation 3).
Ineffective Controls: use of clinical audit software rather than use of Excel as a database for monitoring clinical audit and outcomes.	✓	The Trust was piloting the AMaT clinical audit software at the time of our audit and planned to roll this out across the Trust.
Ineffective Controls: ensuring that review of wider information (e.g., corporate risk register, incidents, complaints, etc) when developing the clinical audit plan is clearly evidenced.	✓	These considerations were incorporated into the VCC Clinical Audit Programme.

Learning from good practice identified

Good practice identified	Trust position	Comments (based on our 2022/23 Trust Clinical Audit Internal Audit)
Approved Clinical Audit Strategy	✓	The Trust's Clinical Audit Strategy is set out in its Clinical Audit Plan
Approved Clinical Audit Plan incorporating national, organisation-wide and local audits	✓	The Trust has an approved Clinical Audit Plan which incorporates relevant audits at all levels.
Approved Clinical Audit Policies & Procedures, including clearly defined roles and responsibilities	◆ !	This was out of scope for our review. The Trust may wish to consider whether it has consistent Clinical Audit Policies and Procedures across its divisions as it continues to develop its clinical audit activities.
Regular clinical audit reporting to Board / Committee	✓	The Board and QSPC receives the Annual Clinical Audit Plan and Report. Going forward, regular updates will be given to the QSPC through the Quality Report, which will allow for triangulation with other quality governance mechanisms.
Clearly identified Clinical Audit Lead for the organisation and locally	✓	The Medical Director is the Trust's Clinical Audit Lead. Local leads have also been identified.
Centralised clinical audit team	! !	The Trust does not currently have a centralised clinical audit team. This was raised as a consideration in our 2022/23 report (recommendation 3).
Participation in national clinical audits	✓	The Trust participates in national cancer audits where appropriate.
Use of clinical audit software such as AMaT	✓	The Trust was piloting the AMaT clinical audit software at the time of our audit and planned to roll this out across the Trust.

Good practice identified	Trust position	Comments (based on our 2022/23 Trust Clinical Audit Internal Audit)
Use of clinical audit registration forms, including objectives, rationale and audit lead / sponsor	◆	Testing this was out of scope for our review at the Trust, although we verified the Trust has a template registration form.
Delivery of clinical audit training	◆ !	Clinical audit training was out of scope for our 2022/23 review. The Trust may wish to consider the level of clinical audit training it provides (including training to use AMaT) as it continues to develop its clinical audit activities.

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

Appendix B: Internal Audit Recommendation Theme Definitions

Theme	Definition
Cyber & Data Management	Management of IT systems and data is inadequate, access rights are not monitored or maintained which may compromise cybersecurity.
Communication	Information is not communicated clearly internally within teams, or externally with partners, forums, or wider stakeholders.
Compliance	Non-compliance with relevant policies, procedures, standards, applicable laws and regulations, and government instructions. No formal compliance monitoring and issue escalation.
Policies & Procedures	Inadequate or lack of policies and procedures in place.
Audit Trail (Documentation)	There are missing or partially completed documents, or the quality of documents is not sufficient. A lack of document retention, unretrievable documents/data or inappropriate audit trail.
Engagement	Lack of engagement with staff, partners, and wider stakeholders. Engagement with external providers is not consistent, resulting in contracts or agreements not being monitored.
Governance & Risk Management	Formal governance routes are inadequate, ineffective, or there is a lack understanding of them. This may affect the ability to identify, assess and manage risk.
Ineffective Controls	The necessary control(s) to mitigate risk(s) do/does not exist, is ineffective, or there are gaps which result in inefficiencies.
Reporting	The adequacy, quality, or accuracy of reporting is insufficient for assurance, or there is a lack of assurance mechanisms and central oversight in place. No formal reporting, escalation, and scrutiny processes are established, all of which may affect the ability to make decisions.
Finances & Resourcing	There are inadequate resources to deliver required tasks, a lack of resource management, monitoring, or funding. Financial viability and sustainability need to be properly considered and maintained.

Theme	Definition
Review	Whilst work is in progress and when it is completed, reviews are not undertaken regularly (or at all) to ensure quality, effectiveness and that the desired outcome is achieved or is on target to be achieved. Best practice is not reviewed or considered, lessons learned are not monitored or documented which may impact development and lead to repeated mistakes.
Physical Security	No consideration and actions to protect against current and future threats.
Planning, Delivery & Deadline Management	A lack of timescales or deadlines being set, or unmonitored scope creep resulting in missed deadlines, non-delivery of projects and/or tasks, overspends, or negative impacts on the quality of the final output.
Training & Development	A lack of training, opportunities to complete training, or training materials within teams; this may lead to gaps in knowledge and over reliance on certain staff members.
Other	If there is no correlation between a recommendation and one of themes outlined, this option can be selected to help monitor the accuracy of the list provided and to identify potential additional themes.

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Heol Billingsley
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Information Governance
Final Internal Audit Report

March 2023

Velindre University NHS Trust

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

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

Contents

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Fieldwork completion:	7th February 2023
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Debrief meeting:	9th February 2023
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Final report issued:	9th March 2023
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit Chris Scott, Audit Manager
Executive sign-off:	Matthew Bunce, Executive Director of Finance
Distribution:	Ian Bevan, Head of Information Governance
Committee:	Audit Committee Quality, Safety & Performance Committee Executive Management Board (Run)

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

Acknowledgement

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

Executive Summary

Purpose

The overall objective of the review was to assess the effectiveness of the Velindre University NHS Trust's (the Trust's) Information Governance (IG) processes and provide assurance that principles and practices are followed and working as intended.

Overview

The Trust has an active IG function which is engaged in the ongoing development and enhancement of the Trust's IG activities.

The audit identified areas for improvement, most of which are covered by the Trust's IG development plan, which is reported quarterly to the Executive Management Board (EMB).

The key matters requiring management attention are:

- the need to improve the Information Asset register; and
- development of a Records Management Strategy and Standard Operating Procedure.

Management should also consider whether the level of IG resource is sufficient and how mandatory IG training update levels can be improved.

Other recommendations are within the detail of the report.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2018/19 Reasonable assurance

Assurance summary[1]

Assurance objectives		Assurance
1	Handling of sensitive information	Reasonable
2	Information Governance training	Reasonable
3	Recording of data breaches	Substantial
4	Governance and oversight	Substantial

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1.1	Improvement actions within IG development plan	1	Design	Medium
1.2	Improvement actions not on IG development plan	1	Design	Medium
2.1	IG resource levels	1	Design	Medium
3.1	Mandatory IG training uptake	2	Operation	Medium

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

1. Introduction

1.1 The review of Information Governance was completed as part of the Velindre University NHS Trust's ('the Trust') 2022/23 Internal Audit Plan. It replaces the deferred Quality & Safety Framework review.

1.2 Information Governance (IG) is a series of best practice guidelines and principles of law to be followed by NHS organisations and their employees in relation to their handling of information. It applies to sensitive and personal information of both employees and patients, as well as corporate information. It is the framework within which accountability, standards, policies and procedures are developed and implemented, to ensure all information created, obtained or received by the Trust is held and used appropriately.

1.3 The Trust uses its IG Framework to meet the legislative and regulatory requirements relating to the handling of information, including compliance with the Data Protection Act (2018), Freedom of Information Act (2000) and Environmental Information Regulations (2004), the latter two of which are not in the scope of this audit but will be subject to separate audits in the future.

1.4 The Trust's IG Framework includes the continuing development, implementation and embedding of robust mechanisms and processes needed for the effective management and protection of its information assets. The IG arrangements are designed to safeguard the information that the Trust holds and ensure the Trust meets the requirements of all relevant legislation

1.5 The audit considered the following risks:

- Inappropriate release of confidential or sensitive data leading to harm; and
- Failure to comply with relevant legislation resulting in financial penalties and reputational damage.

1.6 Compliance with the requirements of the Freedom of Information Act (2000) and Environmental Information Regulations (2004) are not in the scope of this audit.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	3	-	3
Operating Effectiveness	-	1	-	1
Total	-	4	-	4

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

Audit objective 1: Trust systems support the appropriate handling of sensitive information and appropriate measures are taken to prevent data breaches.

IG Framework

2.3 The Trust has in place an Information Governance (IG) framework designed to ensure the Trust meets its mandatory and statutory obligations and other standards in relation to applicable legislation.

2.4 Key features of the Trust's framework comprise the following:

Governance – documents and activities:

- A suite of IG policies and procedures;
- Mandatory training that all Trust staff must complete;
- Tools for recording IG assets and capturing IG incidents and their investigation;
- Regular reporting of recorded incidents etc. through to Board level;
- Reporting of serious data breaches externally to the Information Commissioners Office (ICO); and
- Completion of the annual compliance review (Information Governance Toolkit self-assessment return).

Roles:

- Senior Information Risk Owner (SIRO) who holds responsibility for information risk to the Trust Board. The role is currently held by the Executive Director of Finance;
- Head of Information Governance (HOIG), the lead for Information Governance for the Trust; and
- Caldicott Guardians (Executive Medical Director, supported by two divisional Caldicott Guardians) who provide support to the SIRO to enable information sharing where it is appropriate to share and advise on options for lawful and ethical processing of information.

IG development plan

2.5 In addition to what is currently present, the Head of Information Governance has also created an IG development plan. These are specific tasks required to ensure the Trust is equipped to comply with IG requirements. We were informed that the 19 development tasks in the IG development plan were identified through the 2021/22 IG Toolkit submission.

2.6 The HOIG has undertaken a significant amount of work to progress the tasks within development plan, alongside handling two events with a significant IG

impact (the document storage matter and Covid-19 Inquiry preparation). As of December 2022, six of the 19 tasks had been completed and work is in progress on the remaining 13.

2.7 The six completed tasks are:

- Review of time-expired IG Policies and Equality Impact Assessments;
- Creation of a data sharing agreement template;
- Refresh of the Data Protection Impact Assessment (DPIA) screening process;
- Developing an IG Risk Register (IG risks to be maintained in DATIX);
- Creation of DPIA process for physical security; and
- Review of CCTV systems to ensure DPIAs are in place.

2.8 Of the 13 tasks in progress, 11 fell within the scope of our audit. Our findings on these are summarised below:

Ref*	Actions	Target completion	Internal Audit findings
5.2 3.2	**Information Asset Register (2 tasks)** • Adapt the Information Asset Register (IAR) to more user-friendly format and align with other key IG registers; and • Ensure IAR contains risk treatment plan.	Q3 2022/23 Revised Q1 2023/24	The Trust's IG assets are currently recorded in the Record of Processing Activity (ROPA), which records the key asset attributes listed in the ICO guidance. However, the ROPA is not regularly reviewed, and assets are not risk assessed. Our review of a small number of items from the ROPA identified that one contained inaccuracies. Work is in progress, but delays have been encountered. We understand this is due to divisional resource capacity.
2.4	**Contract Register (1 tasks)** • Create a Contract Register and align with other key IG registers.	Q4 2022/23 Revised Q1 2023/24	A Contract Register is in place for contracts exceeding £25k. Work in progress to: • align the register with other IG registers; and • create a register of contracts between £5k and £25k.
2.5	**DPIAs for Legacy Systems (8 tasks)** • Review DPIAs for legacy systems; • Review legacy systems to ensure all required DPIAs are in place; The above are included as eight individual actions on the plan for each of: • VCC; • WBS; • RD&I, TCS & HTW; and • Corporate	FY 2023/24	Work is in progress around DPIAs for legacy systems, this will be progress during 2023/24 in line with the IG development plan.

Key

Original deadline passed | Not on target to meet deadline | On track to meet deadline

** IG Toolkit reference number, also used in the IG development plan*

2.9 These tasks relate to matters we would usually raise in our reports. However, as the IG development plan is subject to a robust governance and oversight

mechanism[2] and work is clearly in progress on these tasks, we have not raised them as separate matters arising.

2.10 We recommend that the Trust considers whether these matters should be included within the Audit Action Tracker or whether the Audit Committee should receive a progress update thereon, say annually, until the tasks are completed. (**Matter Arising 1**)

2.11 The two IG tasks in progress that are not within the scope of this review are both due for completion by March 2023 and relate to:

- instigating a Data Processing / Sharing Register aligned to other key IG registers; we understand this register is now in use and work is in process to ensure the desired alignment; and
- reviewing and re-publishing the Standard Operating Procedure (SOP) for Freedom of Information.

Records Management

2.12 We sought to establish how the Trust is compliant with the ICO requirements in respect of records management.

2.13 Whilst there is a clear Trust Records Management Policy incorporating the ICO requirements, the Trust does not have a Records Management SOP to support its implementation.

2.14 We noted a task and finish group has been appointed to deliver the Records Management SOP, which will include operational, monitoring and auditing processes.

2.15 We were also informed that the Trust has recognised that a Records Management Strategy (now in development) is needed to support the above Policy and SOP.

2.16 Whilst management of records, including ensuring adherence to relevant codes of practice, is in the business-as-usual (BAU) section of the IG workplan, the development of the Records Management Strategy and SOP is not specifically mentioned. Therefore, these IG development tasks are not subject to the same governance and oversight mechanisms as the tasks identified in paragraph 2.8. (**Matter Arising 1**).

Identifying and mitigating emerging IG compliance Risk

2.17 We sought to establish the processes the Trust operates to identify and mitigate emerging IG compliance risk and noted the following processes:

- Contracts:
  - We were informed that the HOIG uses the Contract Register (£25k+) to identify emerging IG risks linked to contracts, new and existing; and

[2] Progress on the IG development plan is included in the quarterly IG Assurance report to the Integrated Quality & Safety Group and Executive Management Board. It would also be reported to the Quality, Safety & Performance Committee by exception. We tested this governance process under audit objective four, where we gave a substantial assurance rating.

  - Going forward, staff letting contracts between £5k and 25k should also liaise with the HOIG during the contract evaluation process to understand the related IG risks. At present this is a risk area (see paragraph 2.8 and matter arising 1).
- Informal meetings:
  - We were informed that the HOIG meets regularly (informal meetings) with the Trust's Digital Services team to identify any projects where IG risks need to be considered.
- Projects:
  - Project managers receive tailored IG training from the HOIG to assist them in identifying where there may be IG risks that need to be considered.
- Data Protection Impact Assessments
  - DPIAs are undertaken to impact assess the risk of data processing for existing services/systems and for the delivery of new services/systems. Responsibility for this lies with the project/service lead;
  - The HOIG reviews all completed DPIAs to ensure they are undertaken to an adequate standard; and
  - The HOIG maintains a DPIA register to record and monitor the DPIA assessments that have been carried out.

2.18 We examined a small number of DPIAs from the register to verify the process used by the Trust and noted these were compliant with the prescribed process.

Capturing and investigating data breaches

2.19 We noted a well-defined process for the capture and investigation of data breaches is in place. This is examined and tested in audit objective three later in this report.

IG function resource level

2.20 We were informed that the IG challenges faced by the Trust over the past year (the two events noted in paragraph 2.6) have placed an additional strain on the Trust's IG resource (1 FTE HOIG overseen by the SIRO). This is evidenced through tasks in the IG development plan not always being achieved by the target date (see table at paragraph 2.8).

2.21 Whilst we understand these IG challenges are now drawing to a close, the Trust should consider whether it has sufficient resource within the IG function to support its ongoing development and compliance with legislation (**Matter Arising 2**).

Conclusion:

2.22 The Trust has a broad framework to support its objective to comply with IG related legislation.

2.23 IG development and enhancement is ongoing, particularly relating to improving the IAR and the development of a Records Management Strategy and SOP. This

has been considered in the assurance rating for this objective, but as noted in paragraphs 2.9-2.10, separate matters arising have not been raised.

2.24 We identified a medium priority recommendation relating to IG resource capacity.

2.25 Therefore, this objective has been given a **reasonable assurance** rating.

Audit objective 2: Trust staff are provided with information governance training to understand the requirements for the protection of sensitive information and the methods and tools to be used to safeguard it.

2.26 We sought to establish how staff are trained to equip them to deal with IG requirements in their daily roles.

2.27 All staff are required to complete the Trust's mandatory IG ESR training course, which must be renewed every two years. The compliance rate achieved across all areas of the Trust as at December 2022 was 85% (compliance target: 85%).

2.28 However, three of the five areas of the Trust were below the compliance target. We understand that there may be an issue with the uptake of training courses (both ESR and bespoke) due to staff workloads (**Matter Arising 3**).

2.29 The HOIG also delivers tailored training to individuals or groups either in addition to or instead of the mandatory ESR training. This training is not otherwise a part of the Trust's mandatory programme but is considered important for specific roles.

2.30 We reviewed IG training materials delivered to programme and project managers, clinicians, Research, Development & Innovation team members and Trust Board. We found that the scope of the material therein is comprehensive.

2.31 Further, we were informed that in some instances, additional training is given to staff who have been involved in IG related incidents.

2.32 The HOIG keeps a training log of additional IG training given and which staff members have received it.

Conclusion:

2.33 The Trust provides mandatory IG training to all staff through ESR, supplemented by additional training delivered by the HOIG. However, we identified that there appears to be a challenge in some areas in terms of completion of / attendance at IG training, which we were informed is due to staff workload.

2.34 Therefore, this objective has been given a **reasonable assurance** rating.

Audit objective 3: The Trust is compliant with the legislation relating to the reporting of data breaches and other incidents.

2.35 The GDPR introduced a duty on all organisations to report certain types of personal data breaches to the relevant supervisory authority. Failure to do so can result in heavy fines and penalties and an investigation by the Information Commissioner's Office (ICO).

2.36 We sought to establish the mechanisms that the Trust use to identify, investigate, record and report data breaches. Incidents generally require investigation which should be carried out and documented in DATIX by the line manager of the person involved in reporting the incident.

2.37 We noted the following processes in place relating to incident capture:

- A SOP that covers the area and guides incident reporters how to record and document an incident;
- DATIX is used for the recording of incidents by all Trust staff;
- Cases logged in the system are investigated according to their seriousness;
- Case investigations are recorded in the DATIX case investigation form;
- Cases marked as IG related are brought to the attention of the HOIG through automated messaging and are logged;
- Cases are reported internally to the SIRO, the Quality, Safety and Performance Committee (QSPC), and the Executive Management Board (EMB) in the quarterly IG report; and
- Cases are reported to external authorities where the criteria dictate.

2.38 Investigators are taken through a framework of questions asked in the investigation fields. These align with NHS Wales Patient Safety aims and objectives.

2.39 The investigation record is reviewed and signed off by the HOIG before being marked as closed within DATIX.

2.40 The HOIG maintains an incident tracker which records all DATIX incident records. We used this to select a small sample of recent incidents to verify the process in place.

2.41 By reviewing a small number of DATIX incidents, we noted that the DATIX template forms had been correctly populated to create the record of the incident and its investigation. In each instance, the case had been included in the case counts recorded in the tables of the HOIG reports to QSPC and Trust Board.

2.42 IG policy documents include a guide to the scoring (scale from -3 to 13) of the severity of an incident. Cases with a score of 2 or more should be considered for reporting to the ICO. Not in any of the sample cases had the severity been high, or had the case required reporting to the ICO.

Serious data breaches

2.43 Serious cases of data breach may require reporting to the ICO, and further action may be required. The HOIG maintains an additional record of these.

2.44 This was the case for one incident in 2022/23 (the document storage matter). The ongoing investigation and work on this matter has been well documented in reports to the Board and its Committees. As the Trust sought legal advice on this matter, we did not consider it further in our audit.

Conclusion:

2.45 The Trust captures and monitors data breach and other incidents through the Trust-wide DATIX incident recording system and we found no anomalies in the small sample of incidents we examined. Therefore, we have given this audit objective a **substantial assurance** rating.

Audit objective 4: Robust governance and oversight arrangements of the IG function are in place including escalation through to Board.

2.46 We sought to establish the way in which governance and oversight of the IG function operates through an examination of the cycle of regular reporting. The IG governance framework was examined and reported on under audit objective one of this report.

2.47 The HOIG provides a routine quarterly status report (IG Assurance report) to the QSPC, SIRO and EMB. The report outlines key assurance and development activities alongside IG incidents for the reporting period.

2.48 The report is now also being taken to the newly established Integrated Quality & Safety Group to enable triangulation with other quality governance mechanisms prior to being reported to EMB. We understand the report will be further refined and developed to align with the seven levels of assurance approach recently adopted by the Trust.

2.49 There are quarterly meetings between the HOIG, SIRO and Board IG Champion to review the quarterly IG Assurance report in detail.

2.50 Incorporated into the quarterly report through to EMB is a progress update on the IG development plan (paragraphs 2.5-2.11). Progress against the development plan would be reported to QSPC by exception.

2.51 We sought to establish the mechanism used by the Trust for disseminating lessons learned to the wider organisation from data breaches and incidents.

2.52 We noted that targeted staff receive recommendations/ lessons learned from individual DATIX incident reports via DATIX messaging functionality following the investigation of these incidents.

2.53 If an incident is assessed as potentially having a serious impact on the patient / donor or the family of a patient / donor, a Root Cause Analysis investigation may be undertaken in addition to the investigation template within DATIX.

2.54 We noted that a new template is being piloted by Welsh Government for the IG Toolkit and the next submission is due at the end of May 2023.

Conclusion:

2.55 We identified a robust oversight mechanism in operation through the review of the work of the IG function by the Integrated Quality and Safety Group, EMB, QSPC and Board. Therefore, we have given this audit objective a **substantial assurance** rating.

Appendix A: Management Action Plan

Matter arising 1: Areas for Improvement Already Identified (Design)	Impact

Areas in the IG development plan

During our review, we identified several areas for improvement. These tasks relate to matters we would usually raise in our reports. However, as the IG development plan is subject to a robust governance and oversight mechanism (para 2.9) and work is clearly in progress on these tasks, we have not raised them as separate matters arising.

The areas for improvement are set out in paragraph 2.8. In summary, there are eleven related tasks in the development plan covering the following areas:

Area for Improvement	No. of tasks	Original target	Revised target
Information Asset Register	2	Q3 2022/23	Q1 2023/24
Contract Register	1	Q4 2022/23	Q1 2023/24
DPIAs for Legacy Systems	8	FY 2023/24	N/a On target

Key

Original deadline passed | Not on target to meet deadline | On track to meet deadline

Areas not in the IG development plan

The Trust is developing a Records Management Strategy and SOP to support its existing Records Management Policy.

Whilst we note that management of records is in the BAU section of the IG workplan, the development of the Records Management Strategy and SOP is not specifically mentioned. Therefore, these IG development tasks are not subject to the same governance and oversight mechanisms as the tasks identified above.

Potential risk of:

- insufficient progress on identified areas for improvement; and
- breach of relevant IG legislation resulting in potential fines and / or reputational damage.

Recommendations			Priority
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
1.2	Include the development of the Records Management Strategy and SOP in the IG development plan.		Medium
Management response		**Target Date**	**Responsible Officer**
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.	30th June 2023	Head of Information Governance
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.	Achieved	Head of Information Governance

Matter arising 2: IG resource level (Design)	Impact
We were informed that the IG challenges faced by the Trust over the past year (the two events noted in paragraph 2.6) have place an additional strain on the Trust's IG resource (1 FTE HOIG overseen by the SIRO), as evidenced in the table in matter arising 1, where tasks in the IG development plan are not always being achieved by the target date.	Potential risk of: • insufficient progress on identified areas for improvement; and • breach of relevant IG legislation resulting in potential fines and / or reputational damage.

Recommendations	Priority
2.1 Consider whether there is sufficient resources within the IG function to support its ongoing development and compliance with legislation.	Medium

Management response	Target Date	Responsible Officer
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.	30th June 2023	Executive Director of Finance (Senior Information Risk Owner (SIRO))

Matter arising 3: Mandatory IG training uptake (Operation)	Impact
Whilst the Trust's mandatory IG training compliance was at 85% (i.e., in line with the target) as reported in December 2022, three of the five areas of the Trust were below target. We understand that there may be an issue with uptake of training courses (both ESR and bespoke) due to staff workloads.	Potential risk of: • staff not being fully aware of their IG responsibilities; and • breach of relevant IG legislation resulting in potential fines and / or reputational damage.

Recommendations	Priority
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

Management response	Target Date	Responsible Officer
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*".	Achieved	Head of Information Governance

[3] The new IG Toolkit (issued by Welsh Government in February 2023) refers to the 85% target as the 'do maximum' level. The new Toolkit also introduces a 'do minimum' level of 75%.

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Capital Systems
Final Internal Audit Report

March 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

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Executive sign-off:	Carl James, Director of Strategic Transformation, Planning & Digital
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Committee:	Audit Committee

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

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

Disclaimer notice - please note
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Executive Summary

Purpose

This audit was commissioned to evaluate the processes and procedures operating to support the prioritisation and allocation of the Trust's discretionary capital funds.

Overview

Reasonable assurance has been determined at this review.

A robust procedural framework was in place to direct the prioritisation and approval of discretionary capital, with compliance generally evident at Division level, ensuring well-supported capital plans were determined and approved for the 22/23 financial year. Minor points of enhancement have been recommended to ensure this framework remains up to date and supports consistency across Divisions and departments.

Whilst a transparent and well supported recommendation was made to the Executive Management Board for approval of the 22/23 discretionary capital programme, with the paper shared in advance with the Capital Planning Group, associated minutes of the Capital Planning Group meeting at which this was endorsed lacked the necessary detail to provide a clear audit trail of the processes applied.

It is recognised that forthcoming changes to the capital governance structure (including introduction of a Strategic Capital Board), will strengthen the governance arrangements operating in this area.

The key matters requiring management attention include:

- Re-instatement or review of the VCC Business Planning Group;
- The appropriate minuting of Capital Planning Group meetings to provide a clear audit trail of decision making; and
- Where possible, the formulation and approval of the annual discretionary capital programme in a more timely manner.

Other recommendations / advisory points are within the detail of the report.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary [1]

Assurance objectives		Assurance
1	Governance Arrangements	Reasonable
Application of the Prioritisation Framework:		
2	Capital Investment Priorities	Substantial
3	Assessment Criteria	Reasonable
4	Formulation of the Programme	Substantial
5	Recommendation & Approval	Reasonable

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

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
2	The VCC Business Planning Group should be re-instated, or an alternative capital governance structure introduced.	1	Operation	Medium
3	Capital Planning Group meetings should be minuted in more detail and accessible by key parties, ensuring a full audit trail of capital prioritisation and decision making.	1	Operation	Medium
6	The annual discretionary capital programme should be formulated and agreed prior to the start of the financial year wherever possible.	5	Operation	Medium

1. Introduction

1.1 This audit was commissioned to evaluate the processes and procedures that support the management and control of discretionary capital within Velindre University NHS Trust ('the Trust').

1.2 The Trust received a discretionary capital allocation of £1.454m for 2022 – 2023. The audit focused on the systems in place to manage the prioritisation and allocation of these discretionary capital funds.

1.3 A proposed audit programme of potential further Capital Systems reviews, for consideration by the Trust, is included at Appendix B.

1.4 The risks considered in this review included:

- Governance arrangements may be insufficient to provide appropriate direction / scrutiny / approvals.
- The internal control framework may be inadequate to maintain reasonable control of the processes to allocate discretionary capital.
- The programme for bidding may not be well defined or considered, resulting in the preclusion of certain parties.
- The prioritised bids may not reflect the objectives and priorities of the organisation due to inadequate assessment criteria.
- The assessment panel may be poorly constituted, failing to utilise appropriate skills and competences in the assessment of bids.
- The capital programme formulated may not address the priority areas for the organisation and does not align with corporate objectives.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	-	-	-
Operating Effectiveness	-	3	3	6
Total	**-**	**3**	**3**	**6**

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

Governance Arrangements: The establishment of appropriate governance arrangements, including key roles and responsibilities and capital forums; at both Trust and Division level. Audit attendance at a sample of Capital Planning Group meetings, to observe practices in person.

2.3 The Trust's capital procedures were documented within the financial procedure '*FP01 Capital Management Procedure'*, published on the Trust's internet. Whilst remaining largely relevant to the processes evidenced during the audit, the Procedure was out of date, having been last reviewed in 2017 and scheduled for review in 2020. It is recognised a review was initiated but then postponed due to the focus on Covid priorities (**MA1**).

2.4 This outline capital procedure was supported by the more detailed '*Capital Planning Prioritisation Framework'*, which clearly defined the discretionary capital prioritisation process. The Framework was in date at the time of the current review, and had been agreed by the Executive Management Board (2020). It was noted that the procedure will require updating over the coming months to reflect the forthcoming changes to the capital governance structure (see para. 2.8).

2.5 The agreed capital governance structure in place at the time of review comprised of the following:

- Trust Capital Planning Group, reporting to the Executive Management Board;
- Welsh Blood Service (WBS) Capital & Procurement Planning Group, reporting to the WBS Senior Management Team; and
- Velindre Cancer Centre (VCC) Business Planning Group, reporting to the VCC Senior Leadership Team.

2.6 Whilst the Trust Capital Planning Group and WBS Capital & Procurement Planning Group had met as required during the 22/23 capital planning cycle, the VCC Business Planning Group had not met routinely as agreed within its terms of reference. This was attributed by management to a largely inherited capital programme carried over from prior years, reducing the need for regular capital planning and prioritisation meetings (**MA2**).

2.7 We experienced difficulty in obtaining minutes for Capital Planning Group meetings, with management advising whilst these had been prepared and filed, they could not be easily accessed by all relevant parties. Further, minutes for the October 2022 meeting had not been prepared in readiness for approval at the November 2022 meeting (observed by Audit) (**MA3**).

2.8 Attendance at the Capital Planning Group meetings reviewed was not in accordance with the membership defined within the agreed terms of reference. Whilst the Divisions and relevant departments were well represented, this was at a largely operational-management level, as opposed to the agreed Director-level membership.

2.9 Whilst noting the above, changes in the Trust's capital governance structure are proposed i.e. with a new Strategic Capital Board recently agreed to lead the development and delivery of the Trust's capital programme (reporting to the Executive Management Board). The current Capital Planning Group will become a Capital Delivery Group, to oversee the detailed delivery of capital schemes. Draft terms of reference had been developed for both forums, in readiness for implementation of the new structure for the new financial year. Recognising that the new terms of reference address the issues with membership and attendance noted above, a recommendation has been made that this be approved and implemented in a timely manner to support the wider change timeline (**MA4**).

2.10 **Reasonable assurance** has been determined in respect of the defined governance arrangements in place at the time of review (however the operational arrangements should be enhanced). It is recognised that the introduction of the new Strategic Capital Board will further strengthen arrangements going forward.

Prioritisation Framework: Assurance that the methodology for the allocation of discretionary capital funding between divisions and departments has been clearly determined and applied.

As per para. 2.4, the Trust has developed a '*Capital Planning Prioritisation Framework'*, which clearly defines the discretionary capital prioritisation process. Compliance with the same has been assessed as follows:

Capital Investment Priorities - the proposals for the identified priorities contained appropriate standardised information to enable evaluation (e.g., objectives, benefits, capital/ revenue costs).

2.11 The process for prioritising discretionary capital investments from across the Trust is summarised within the Capital Prioritisation Framework over three key steps.

2.12 Step 1 takes place at Division / department level and is defined as follows:

> *WBS / VCC / Estates / Digital are required, each financial year, to submit their capital bids in priority order. These priorities must be endorsed by an appropriate group e.g. VCC / WBS Senior Management Teams. In addition each prioritised scheme must be supported by a complete capital prioritisation information template.*

2.13 To assess compliance with the defined procedure, the identification of capital investment priorities, and associated completion of the required documentation, was reviewed for Velindre Cancer Centre, Welsh Blood Service and Estates. Noting the process for prioritisation of Digital equipment requirements was more straight forward (focusing on the replacement of IT equipment), this was not included

within the detailed audit review. Digital projects managed on behalf of the Divisions, however, were captured.

2.14 A robust process had operated for the 22/23 capital planning cycle in each Division and Estates, ensuring liaison with relevant stakeholders to identify potential priority investments.

2.15 The Capital Prioritisation Information Template is designed to capture details of each capital priority, ensuring key information regarding the proposed investments can be documented in a consistent manner, supporting comparison and prioritisation both within the Divisions and by the Capital Planning Group. This included:

- The benefits of the proposed investment;
- Risks of not receiving funding;
- The forecast delivery timeframe;
- Estimated capital and revenue costs;
- Compliance with the agreed Critical Success Factors; and
- Key drivers (e.g. compliance, service continuity etc).

2.16 For the majority of capital priorities reviewed, the Capital Prioritisation Information Template had been appropriately completed to support the bids. A few exceptions were noted, including inconsistency between the Divisions and Estates in the application of the Templates in the allocation of the £50k discretionary funds. The Capital Prioritisation Framework should provide clarity as to the expectations in such areas (**MA5**).

2.17 Completed bids were subsequently assessed and prioritised at Division level, with the recommended capital priorities approved at the Division Senior Leadership/Management Teams (see para. 2.5/2.6 re the supporting capital governance structure) before being considered by the Trust's Capital Planning Group.

2.18 Noting scope for minor enhancements to the procedural guidance, **substantial assurance** has therefore been determined in this area.

Assessment Criteria – Assurance that the assessment criteria is standardised and aligned with the key objectives of the organisation/ wider health community. Weightings are agreed in advance by an appropriate forum and are known to all bidders. Assessment was undertaken by a suitable individual/ group.

2.19 A standardised assessment criteria was clearly defined within the Capital Prioritisation Framework, and ensured alignment with wider organisational objectives through the mapping of each scheme to the agreed Critical Success Factors: *"Critical Success Factors are essential attributes to consider in the*

development of all capital proposals. Capital proposals which cannot demonstrate that they comply with the following Critical Success Factors (where applicable) will not be considered for capital funding" (para 5.1). These have been identified as:

1. Strategic Fit and Business Needs; and
2. Sustainable Development & Well-being of Future Generations.

2.20 As per para. 2.15, the completion of the Capital Prioritisation Information Template requires demonstration of alignment with the Critical Success Factors. The same had been completed for the majority of schemes included in the 2022/23 Discretionary Capital Programme for the sample reviewed (i.e. WBS, VCC and Estates) (see **MA5**).

2.21 Step 2 of the Trust's Capital Prioritisation Framework was defined as follows:

> *Trust Capital Planning Group to evaluate capital bids and produce a recommended Trust Capital Programme for consideration by the Trust Executive Management Board.*

2.22 As per para. 1.2, the Trust received a discretionary capital allocation of £1.454m from Welsh Government for 2022/23.

2.23 Of this total allocation, £1.099m was already allocated to pre-agreed commitments. These included schemes which had already been approved during 2021/22 (but which the Trust had not been able to progress due to a focus on delivery of Covid priorities), ring-fenced £50k allocations to each of VCC, WBS, Estates and Digital (to spend at their discretion) and capitalised Estates salaries (see table at Appendix C for the full discretionary programme).

2.24 A further £434k was allocated to support the delivery of the Integrated Radiotherapy Solution (IRS). At this time, Welsh Government approval of the business case was awaited, and the Trust was confident these costs would be reimbursed later in the year, at which point these monies would be released back into the discretionary capital programme for re-allocation.

2.25 These allocations gave an over-commitment of circa £79k: however the Capital Planning Group reported it was confident this was manageable noting contingency sums had been included within each allocation, and the potential for delivery of some schemes to slip into 2023/24.

2.26 Noting the above, there was no opportunity at the start of the year for the Capital Planning Group to assess and prioritise any other schemes for inclusion within the 2022/23 plan. We did find however, that the minutes captured from the July 2022 meeting at which the above was endorsed, were insufficient in detail to provide a clear audit trail of the process applied (particularly in respect of schemes added to the programme mid-21/22, which had not therefore previously been approved by

the Executive Management Board at the start of 21/22, and the associated financial allocations) (see **MA3**).

2.27 Noting the above, **reasonable assurance** has been determined in this area.

Formulation of the Programme - The method of formulating the discretionary capital programme links to the previous prioritisation process and is transparent.

2.28 Step 2 of the Capital Prioritisation Framework, as referenced above, incorporated the development of a recommended Discretionary Capital Programme.

2.29 We were able to evidence the appropriate formulation of the 2022/23 Discretionary Capital Programme, deriving from the priorities agreed at the July 2022 Capital Planning Group. However, as noted above, whilst the programme was reported to be largely formulated from 21/22 legacy schemes, there could have been improved clarity over the inclusion of those schemes which were approved mid-21/22, which had not previously been approved by the Executive Management Board. See Appendix C for the agreed Programme recommended for approval.

2.30 Recognising this is a matter of audit trail only, and has been considered in the assurance rating determined in the ***Assessment Criteria*** section, **substantial assurance** has therefore been determined in this area.

Recommendation / Approval: To obtain assurance that the discretionary capital programme was presented to an appropriate forum for approval and included details of the rationale applied and resulting priorities. Any conditions/ caveats were clearly highlighted and explained. Arrangements were in place for obtaining approval to amend the programme subsequent to its formulation.

2.31 Step 2 of the Capital Prioritisation Framework, as referenced above, incorporated the development of a recommended Discretionary Capital Programme.

2.32 Step 3 of the Capital Prioritisation Framework covered the approval of the Discretionary Capital Programme, as follows:

> *Approval of the Capital Programme by the Trust Executive Management Board.*

2.33 The 2022/23 Discretionary Capital Programme as endorsed by the Capital Planning Group was presented to, and approved at the Executive Management Board on 27 July 2022. The recommendation included transparent rationale behind the formulation of the programme, linked to the Capital Prioritisation Framework requirements.

2.34 The approved programme was subsequently presented to the Strategic Development Committee for noting.

2.35 Whilst recognising the 2022/23 Discretionary Capital Programme was largely comprised of schemes carried forward from the year prior, the approval was late in the year: not achieved until July 2022. This reduced the time available to deliver the agreed schemes (and achieve the associated benefits) in-year. Slippage of schemes into subsequent years will continue to have a knock-on effect on subsequent years' planning if the cycle continues as it currently operates (**MA6**).

2.36 In October 2022, the Trust was asked by Welsh Government to identify priority capital schemes which could be delivered by year-end, should additional funding become available. Divisions, Estates and Digital were requested to update their priority listings to support this request. This exercise resulted in a list of Priority 1 and Priority 2 schemes endorsed by the Capital Planning Group on 19 October 2022 and approved by the Executive Management Board on 21 November 2022. The previously agreed ring-fenced funding for the Integrated Radiotherapy Solution (see para. 2.24) was also released at this time, meaning some of the Priority 1 schemes could commence delivery whilst Welsh Government feedback on additional funding was awaited. The Executive Management Board delegated authority to the Capital Planning Group to manage the allocation of the remaining funds in line with the approved priorities, including slippage into 23/24 if required.

2.37 Noting the above, **reasonable assurance** has been determined in respect of recommendation and approval. The re-alignment of the capital planning cycle with the start of the financial year would improve assurance in this area.

Appendix A: Management Action Plan

Matter Arising 1: Governance – Capital Procedures (Operation)			**Impact**
The Trust's capital procedures were defined within the document 'FP01 Capital Management Procedure,' published on the internet site. The document was last approved in 2017 by the Executive Management Board (EMB), and was scheduled for review in 2020. Whilst recognising the document remained largely relevant at the time of the audit, some details required updating. It is also noted the Trust's capital governance structure is changing, with a new Strategic Capital Board to sit beneath EMB. As part of this change, the existing Capital Planning Group will become a Capital Delivery Group. These forthcoming changes will also need reflecting in the above procedure document.			Potential risk of: • Documented guidance does not reflect current processes. Potential for confusion / mis-management.
Recommendations			**Priority**
1.1	FP01 Capital Management Procedure should be reviewed and updated.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Accepted: The Capital Management Procedure will be updated and will be submitted for approval following Trust governance requirements.	30 November 2023	Head of Financial Planning & Reporting

Matter Arising 2: Governance – Divisional Structure (Operation)		**Impact**
Appropriate governance structures had been established at both Velindre Cancer Centre (VCC) and Welsh Blood Service (WBS), to support the capital management process. At WBS, the Capital & Procurement Planning Group had endorsed the 2022/23 capital priorities, with subsequent approval by the Senior Management Team. At VCC, whilst a Business Planning Group had been established, it had not met with the agreed frequency (as per its terms of reference) during 21/22 and 22/23. The 22/23 capital priorities were approved by the Senior Leadership Team on recommendation by the Planning & Performance team. It is recognised that the 22/23 discretionary capital plan incorporated a number of legacy schemes, previously approved but which had not progressed in the prior year due to prioritisation of Covid schemes. Therefore there was a reduced need for the VCC forum to meet in respect of capital prioritisation in readiness for 22/23. The VCC Planning & Performance Manager has already committed to a review of the business planning structure in readiness for the 23/24 financial year, including a review of existing forums and terms of reference.		Potential risk of: • Insufficient oversight of capital prioritisation and delivery. • Capital may not be appropriately allocated.
Recommendations		**Priority**
2.1	The 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**

Agreed Management Action		Target Date	Responsible Officer
2.1	Accepted: The VCC Business Planning Group will be re-instigated in line with the approved Term of Reference.	30 June 2023	Director of Cancer Services, Velindre Cancer Centre

Matter Arising 3: Governance – Capital Planning Group (Operation)	**Impact**
We attended the November and December 2022 Capital Planning Group meetings, to observe the operation of the forum in person. We additionally reviewed a further sample of Capital Planning Group minutes (July 2021, July 2022 and October 2022), to assess compliance with the requirements of the Capital Prioritisation Framework and with the Group's agreed terms of reference, in the prioritisation and agreement of the 2022/23 discretionary capital programme and mid-year adjustments. The following issues were noted from this exercise: • Requested minutes were slow to be provided, with management advising that whilst they had been prepared and filed, this was not in a location accessible to all relevant officers; • At the November 2022 meeting, minutes from the prior meeting had not been prepared in readiness for approval; • For all meetings reviewed, attendance was not in accordance with the membership agreed in the terms of reference. Agreed membership was set largely at Director-level, but in practice attendees were at an operational management level, with the exception of the Director of Finance who attended 3/5 meetings. Recognising the aforementioned forthcoming changes to the governance structure, the draft terms of reference for the new Capital Delivery Group (see **MA4**) addresses the level at which membership is set, and therefore a recommendation has not been made; and • Whilst recognising the appended paper provided detailed narrative as to the proposed 22/23 discretionary capital programme, the minutes of the July 2022 meeting at which this was endorsed do not provide a sufficiently clear audit trail of the processes undertaken in the formulation of the programme (recognising that, whilst the majority of schemes included had previously been approved in 2021/22, some new schemes had been added mid-year, and the associated financial allocations also needed to be confirmed).	Potential risk of: • Insufficient audit trail to demonstrate compliance with agreed procedures and best practice in the allocation of discretionary capital funding.

Recommendations		Priority
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**

Agreed Management Action		Target Date	Responsible Officer
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.	30 June 2023	Deputy Director of Planning & Performance

Matter Arising 4: Governance – Capital Delivery Group Terms of Reference (Operation)	**Impact**
In readiness for the aforementioned changes to the capital governance structure, a terms of reference had been drafted for the new Capital Delivery Group. The roles, responsibilities and membership of the forum had been appropriately defined. However, the document was in draft at the time of review, awaiting approval. It should be ensured this is approved at an appropriate forum (e.g. the new Strategic Capital Board) in a timely manner, to enable initiation of the governance changes in line with the wider change timeline.	Potential risk of: • The new Capital Delivery Group remit is not approved and initiated in a timely manner. • Potential delay in progression of the 2023/24 discretionary capital programme.

Recommendations		**Priority**
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**

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Accepted: The revised terms of reference will be submitted for approval through Trust agreed governance arrangements.	30 June 2023	Director of Strategic Transformation, Planning & Digital

Matter Arising 5: Prioritisation Framework – Consistency of application (Operation)	**Impact**
The Capital Prioritisation Framework requires each Division, Estates and Digital to submit their prioritised capital bids for endorsement by an appropriate group (e.g. Senior Management Team), supported by a completed Capital Prioritisation Information Template. The Templates had been appropriately completed for the majority of bids reviewed during the audit, with some minor exceptions noted, as follows: • Where schemes had already been approved at Board level, with detailed business cases in place. This is deemed appropriate, as completion of the Template would not add any additional information; • At one VCC scheme added to the Discretionary Capital Programme mid-year, following a compliance audit. Whilst recognising the results of the compliance audit supported the need for capital investment, completion of the Template would have ensured consistency in documentation of the business need and facilitated comparison to other bids by the Capital Planning Group; and • Whilst VCC and WBS completed Templates for schemes funded from their £50k discretionary allocation, the same had not been done in Estates. It is noted the Capital Prioritisation Framework does not provide specific guidance on the requirement for management of discretionary allocations, or as to whether there are acceptable exceptions to the Capital Prioritisation Information Template process.	Potential risk of: • Inadequate guidance, resulting in inconsistent application of procedures between Divisions and Departments.

Recommendations		**Priority**
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**

Agreed Management Action		Target Date	Responsible Officer
5.1	Accepted: The Capital Prioritisation Framework will be reviewed and updated in line with the recommendation.	30 June 2023	Deputy Director of Planning & Performance

Matter Arising 6: Prioritisation Framework – Annual Approval Timeline (Operation)	**Impact**
For the 22/23 discretionary capital programme, the following timeline was evidenced in respect of the approval of capital priorities: • WBS: Endorsement of capital priorities by the Capital & Procurement Planning Group on 3 March 2022, and approval by the SMT on 9 March 2022; • VCC: Approval of capital priorities by the SLT on 30 June 2022; • Endorsement of the Discretionary Capital Programme by the Trust Capital Planning Group on 19 July 2022; and • Approval of the Discretionary Capital Programme by the Trust Executive Management Board on 27 July 2022. The late approval of the Discretionary Capital Programme reduces the time available in-year to deliver the agreed schemes and achieve the identified benefits. It is recognised that the unique pressures of responding to the Covid pandemic in the last few years have disrupted the annual capital planning cycle: with focus on delivery of Covid schemes and an associated reduction in remaining resources to deliver other priorities. As a result, the 22/23 plan largely comprised of legacy schemes agreed in prior years, which had not yet been delivered. This reduced the urgency with which the annual discretionary programme needed formal approval. It is noted however that in the majority of other NHS Wales organisations for 22/23, the annual discretionary capital programme was agreed ahead of the start of the financial year. Moving forward, as previously referenced a new capital governance structure will be in place, and the setting of the Discretionary Capital Programme will be the responsibility of the new Strategic Capital Board.	Potential risk of: • Insufficient time to deliver the agreed capital priorities by year end; • Failure to achieve the required benefits.

Recommendations			Priority
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**
Agreed Management Action		**Target Date**	**Responsible Officer**
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.	31 March 2024 and ongoing thereafter	Director of Strategic Transformation, Planning & Digital With support from VCC and WBS.

Appendix B: Capital Systems proposed audit programme

A proposed annual programme to review the capital systems in place in the Trust is outlined below, following on from the overarching prioritisation and approval process reviewed at this audit. Requirements at each stage would be tailored to the Trust's capital procedures in respect of project delivery, with commentary also to be provided as to the adequacy of those procedures in controlling the delivery of capital schemes.

Financial Year	Proposed Capital Systems Coverage
2023/24	**Initiation Phase** • Initiation of project governance arrangements, including key appointments and establishment of the project board (where required) • Development of the initial/outline brief **Scheme Management** • Project Execution Plan • Cost control forms • Risk management arrangements • Management control plan • Issues log • Change control arrangements **Advisers** • Appointment of appropriate advisers • Use of frameworks, local tender arrangements, call of contracts as appropriate • Formalisation of appointments
TBC (could be combined with the above dependent on the number / size of schemes in the annual plan).	**Design** Areas of coverage may include: • Adequacy of Briefing information and stakeholder engagement; • Design development and sign-off controls; • Compliance with statutory planning requirements; • Adequacy of Project Team reporting; • Adequacy of cost planning and reporting arrangements; • Consideration of Health and Safety requirements; • Project Board reporting and approvals etc.
TBC	**Procurement** Areas of coverage may include: • A procurement strategy has been considered at the inception of the scheme • Compliance with SOs/ SFIs • Compliance with Single Tender Action/Waiver requirements • Completion of Declarations of Interest • Financial vetting • Technical vetting

Financial Year	Proposed Capital Systems Coverage
	• Recommendation to award the contract • Notification letters issued to successful/unsuccessful tenderers • Full cost of scheme updated in the Business Case • Management of schemes exceeding initial budget estimates • Execution of contract/s
TBC	**Construction Phase & Completion** Areas of coverage may include: • Pre-start meeting held • Cost monitoring and reporting • Progress monitoring and reporting • Change Management processes • Control of Contractors • Interim valuations and payments • Practical completion process including snagging/defects schedule, agreement of defects period, dates for handover of O&M manuals, H&S File etc. • Adequacy of operational commissioning; • Final account produced and agreed, including deductions for liquidated damages where appropriate • Release of retention monies • End of defects period certification • Post project evaluation and reviews completed

Appendix C: 2022/23 Approved Discretionary Capital Programme

Scheme Name	£000
Discretionary Capital Funding	**1,454**
VCC	
VCC Discretionary Capital Allocation	50
CRW Refurbishment	126
Gift Shop Conversion	20
WBS	
WBS Discretionary Capital Allocation	50
EDRM	125
WTAIL IT System	150
Other	
Estates Salaries	125
Estates Discretionary Capital Allocation	50
Ventilation Works	153
Fire Safety - Emergency Lighting	140
Trust Capital Planning Post	21
Digital Discretionary Capital Allocation	50
Integrated Radiotherapy Solution	434
Schemes Total	**1,533**
Over (-)/ Under (+) Commitment at start of year	-79

Appendix D: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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AUDIT COMMITTEE

AMENDMENT TO STANDING ORDERS – SCHEDULE 3 ANNUAL TERMS OF REFERENCE REVIEW: QUALITY, SAFETY & PERFORMANCE COMMITTEE, RESEARCH, DEVELOPMENT & INNOVATION SUB-COMMITTEE and CHARITABLE FUNDS COMMITTEE

DATE OF MEETING	25th April 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer Sandra Cusack, Business Support Officer Sarah Townsend, Head of Research & Development Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff Nicola Williams, Executive Director of Nursing, AHPs & Health Science Dr. Jacinta Abraham, Executive Medical Director Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	02/03/2023	ENDORSED

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Research, Development & Innovation Sub-Committee	15/11/2022	ENDORSED
Quality, Safety & Performance Committee	16/03/2023	ENDORSED
Charitable Funds Committee	21/03/2023	ENDORSED

ACRONYMS	
	N/A

1. SITUATION

The purpose of this report is to outline the required changed to the Trust Standing Orders – **Schedule 3**, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the: **Quality, Safety & Performance Committee, Research, Development & Innovation Sub-Committee and Charitable Funds Committee**, (ref. ***Appendix 1, 2 & 3*** [with track changes] & ***Appendix 4, 5 & 6*** [without track changes]. The purpose of the report is to seek formal **ENDORSEMENT** by the Trust Audit Committee prior to submission to Trust Board for formal **APPROVAL**.

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 Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

The amendments detailed in this report have been formally received and **ENDORSED** for Board **APPROVAL** by the Quality Safety & Performance Committee, Research, Development & Innovation Sub-Committee and Charitable

Funds Committee, included at ***Appendix 1 – 6***.

The annual review cycle for the Terms of Reference for each Committee will now be March each year in line with the Trust full annual reporting cycle. However, once work that is being undertaken by the Trust Integrated Quality & Safety Group on the meeting structure is concluded, the Quality Safety & Performance Committee organogram will need to change and these changes will be brought for further approval. It is anticipated that this work will be concluded by July 2023.

Tables 1 - 3 provide a high level summary of the key changes to the Quality, Safety & Performance Committee, Research, Development & Innovation Sub-Committee and Charitable Funds Committee Terms of Reference respectively:

Table 1: Quality, Safety & Performance Committee

Terms of Reference & Operating Arrangements	**Summary of Amendments**
Quality, Safety & Performance Committee	**Section 6 (Relationships & Accountabilities with the board and its Committees / Groups):** Addition of confirmation that the Committee has approved the establishment of an Integrated Quality & Safety Group, to support the Committee in effectively executing its responsibilities by undertaking quality and safety intelligence triangulation / analysis and learning assurance to facilitate enhanced efficiency of reporting to the Committee (**ref. 6.6**).
Quality, Safety & Performance Committee	**ANNEX 2 – Wider Governance & Accountability Framework:** Addition of Trust Integrated Quality & Safety Group and associated reporting structure.

Table 2: Research, Development & Innovation Sub-Committee

Terms of Reference & Operating Arrangements	Summary of Amendments
Research, Development and Innovation Sub-Committee	**Section 3:** - Removal of reference to the Chief Executive's Financial limit / delegated authority in the context of business cases that are received by the Committee (**ref.3.2**). More clearly articulated and clarified role of Committee in reviewing and scrutinising financial bids for approval.
Research, Development and Innovation Sub-Committee	**Section 4:** - Membership revised to state a minimum of **3** members, including **2** Independent Members of the Board. - Staff Side Representative no longer listed as a Standard Attendee of the Committee.
Research, Development and Innovation Sub-Committee	**Section 6:** - Addition and clarification of the role of the Advancing Radiotherapy Fund Programme Board and Advancing Radiotherapy Fund Advisory Group with the RD&I Sub-Committee and Charitable Funds Committee (**ref.6.4**) **Appendix 1 - RD&I Meeting Structure** Added **Advancing Radiotherapy Fund Programme Board** and **Charitable Funds Committee** to organogram.

Table 3: Charitable Funds Committee

Terms of Reference & Operating Arrangements	Summary of Amendments
Charitable Funds Committee	**Section 5: Authority** - Date of the Financial Services Act updated to state 2021. **Section 5.4: Sub Committees** - The inclusion of the relationship of the Advancing Radiotherapy Fund Programme Board with the Charitable Funds Committee **Section 6.2: Attendees** - Inclusion of: o Executive Director of Nursing, AHPs & Health Science o Head of Financial Planning & Reporting

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Evidence suggests there is a correlation between governance behaviours in an organisation and the level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Audit Committee is asked to **ENDORSE** the amendments to the Trust Standing Orders – **Schedule 3,** as outlined in section **3** of this report, and included in ***Appendix 1-6,*** prior to Trust Board **APPROVAL.**

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

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

1. INTRODUCTION

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

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

2. PURPOSE

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

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

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

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

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

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

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

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Authority

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

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

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

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

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

Access

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

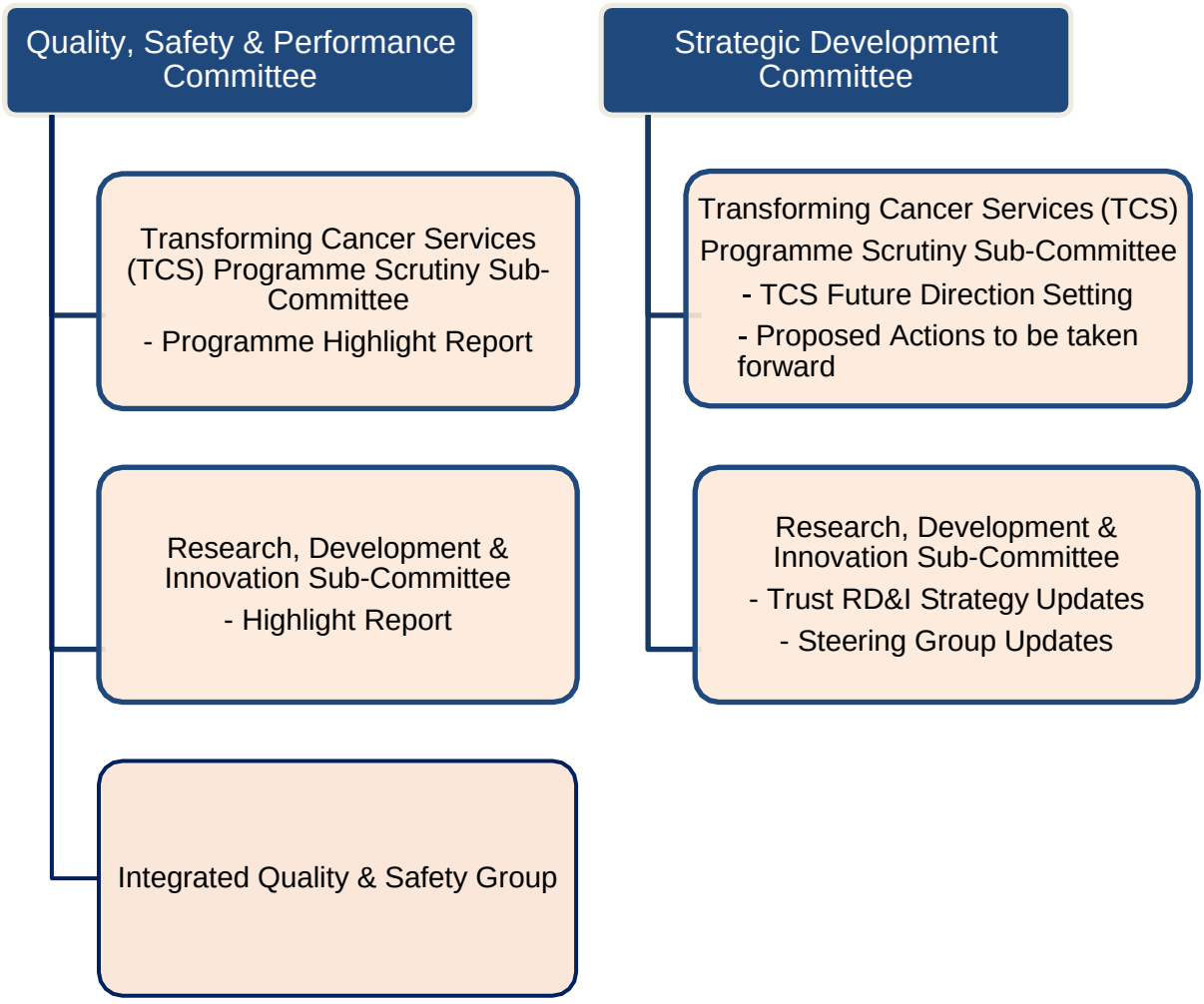
Sub Committees

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

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

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

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



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

4. MEMBERSHIP

Members

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

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

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

4.2 Attendees:

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

4.3 By invitation

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

- Healthcare Inspectorate Wales
- Audit Wales

- Trade Unions
- Community Health Council

Secretariat

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

Member Appointments

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

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

Support to Committee Members

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

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

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

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

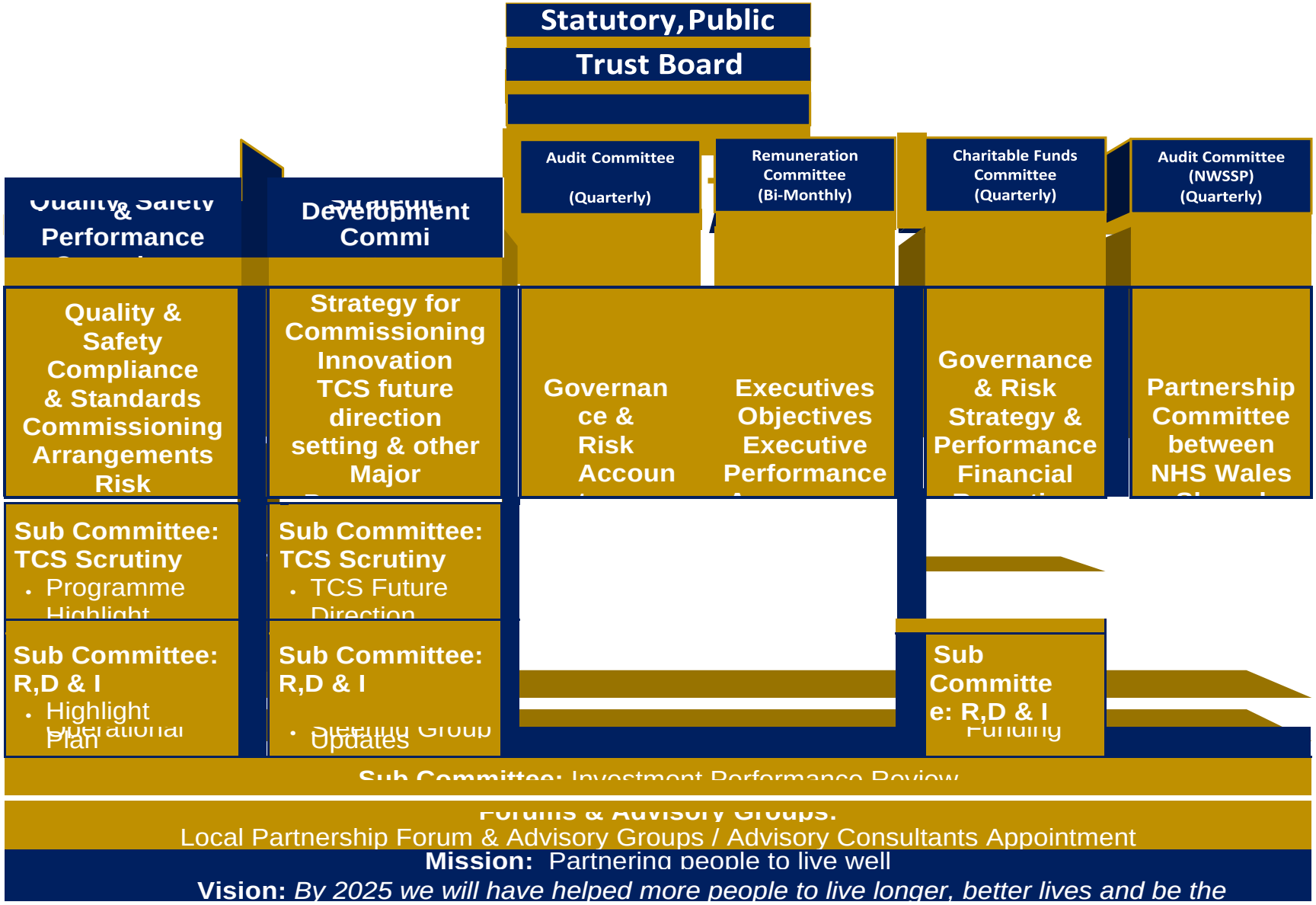
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

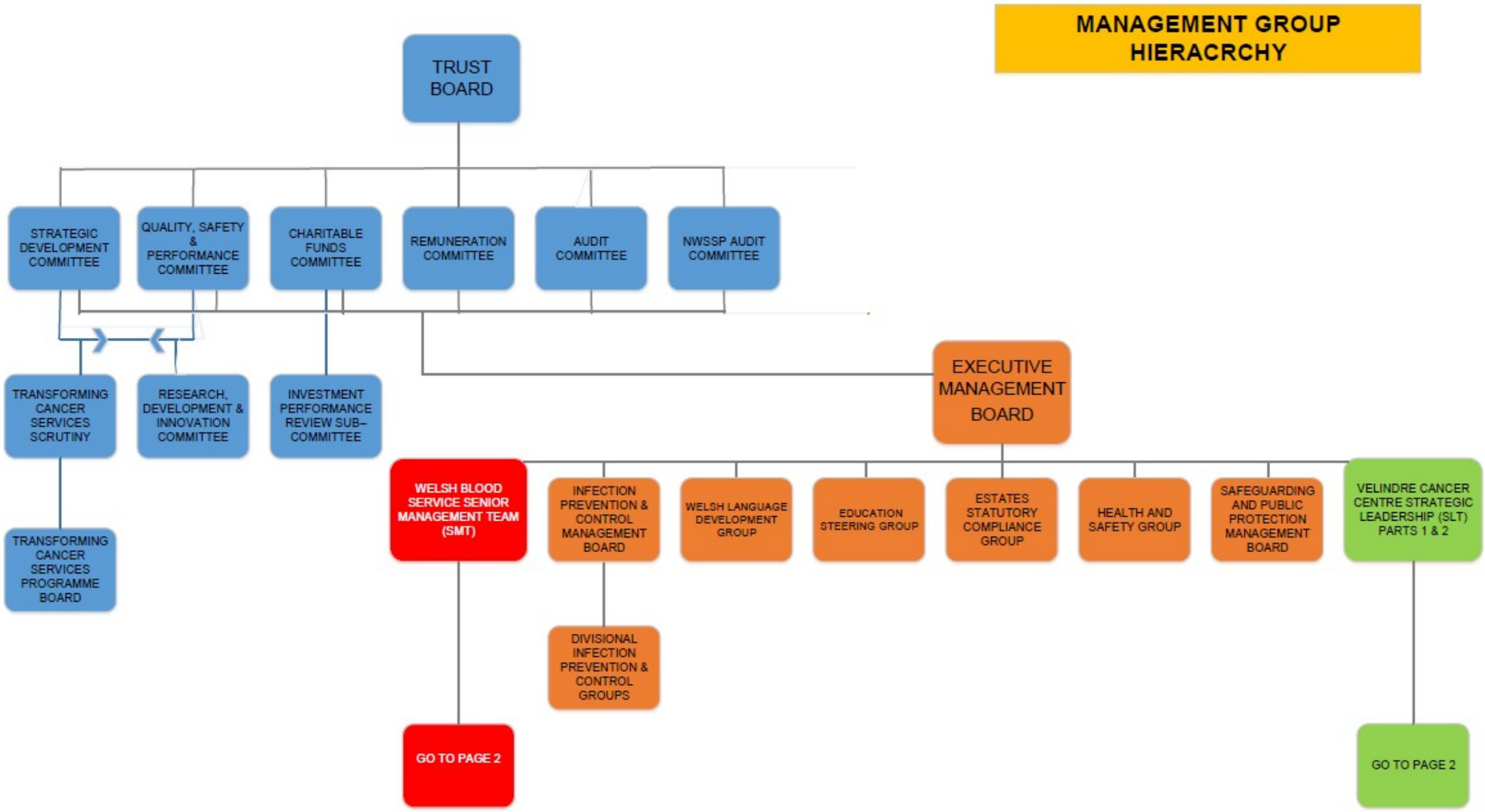
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf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

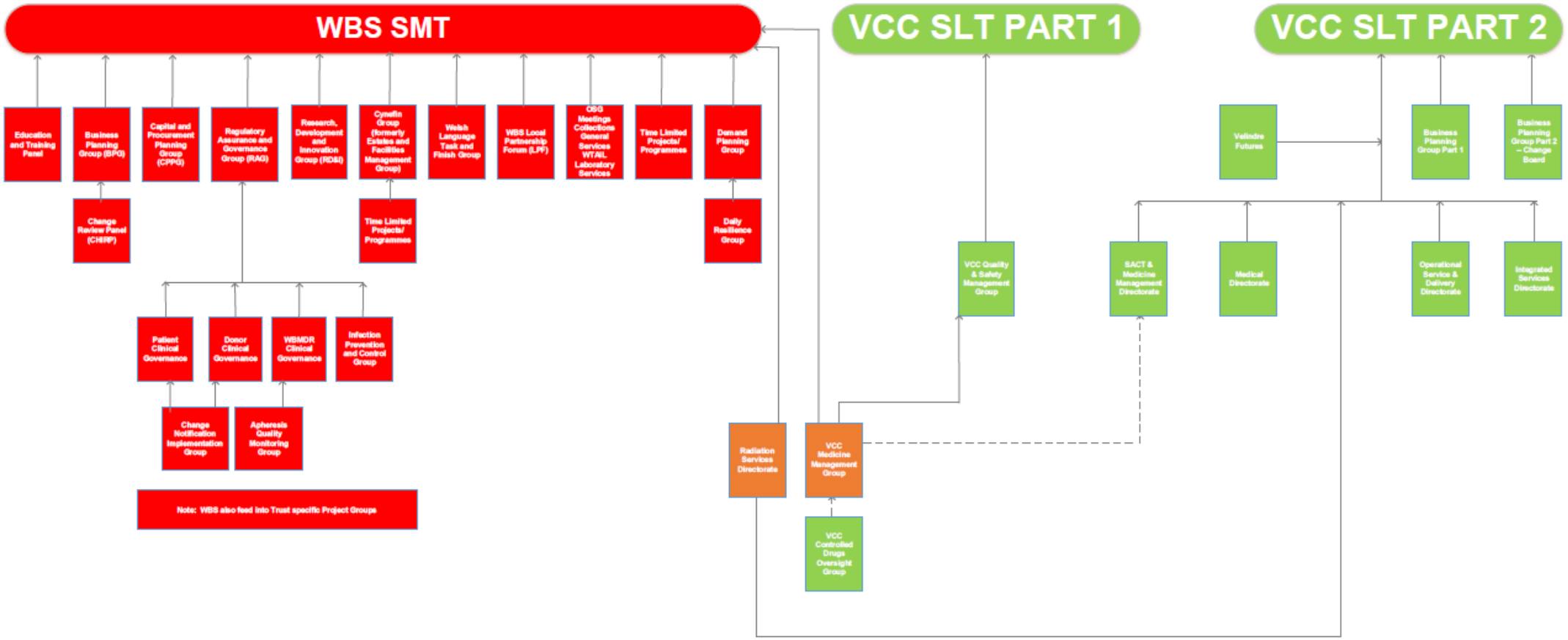
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK




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

Research, Development & Innovation (RD&I) Sub-Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
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.

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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:

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Chair	Independent member of the Board (University) or delegated Independent Board member
	Two Independent Members of the Board

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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

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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**

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.

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.

4.6 **Support to Committee Members**

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

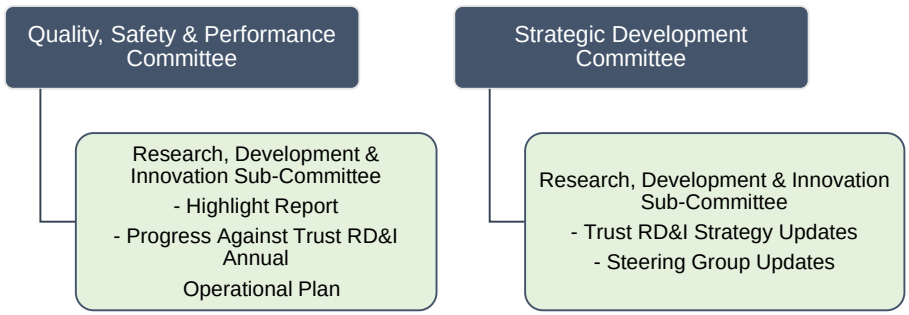
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. SUB-COMMITTEE MEETINGS

5.1 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.

6.4 The Sub-Committee is supported by the **Advancing Radiotherapy Fund (ARF) Programme Board,** established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the RD&I Sub-Committee that is subject to formal endorsement by the RD&I Sub-Committee prior to the formal approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the RD&I Sub-Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board is also supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 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

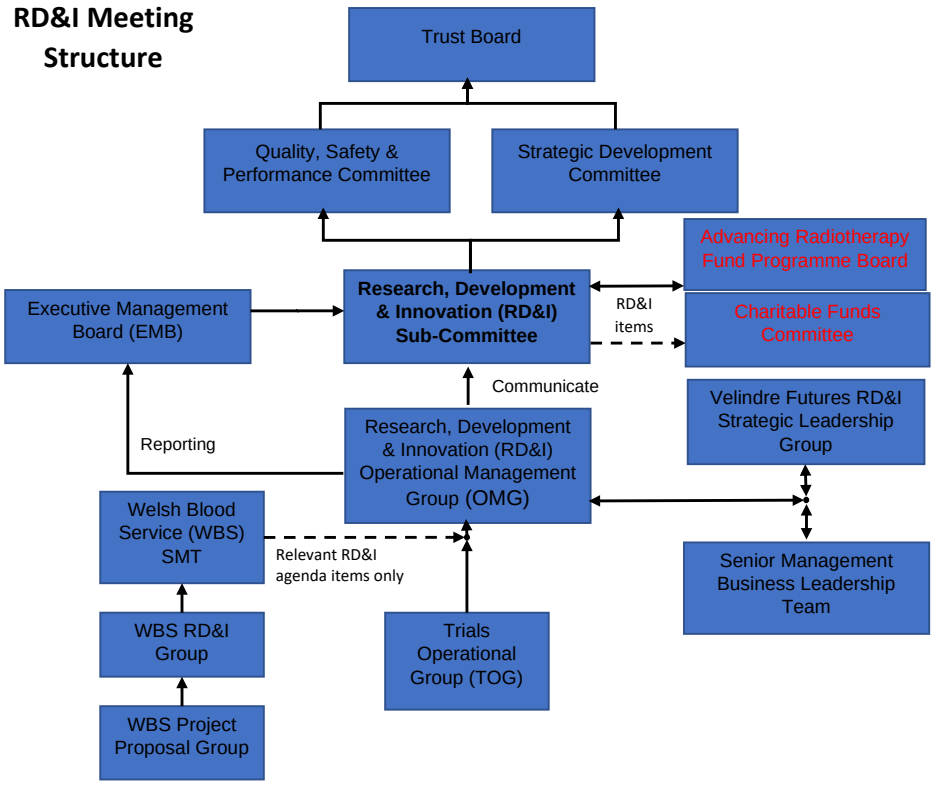
9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee with reference to the Board.

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
Trust Board
Quality, Safety & Performance Committee
Strategic Development Committee
Advancing Radiotherapy Fund Programme Board
Executive Management Board (EMB)
Research, Development & Innovation (RD&I) Sub-Committee
RD&I items
Charitable Funds Committee
Communicate
Velindre Futures RD&I Strategic Leadership Group
Reporting
Research, Development & Innovation (RD&I) Operational Management Group (OMG)
Welsh Blood Service (WBS) SMT
Relevant RD&I agenda items only
Senior Management Business Leadership Team
WBS RD&I Group
Trials Operational Group (TOG)
WBS Project Proposal Group

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2023
Approved:	
Next Review due:	March 2024

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*".

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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.

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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 2021.
    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

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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.

The **Advancing Radiotherapy Fund (ARF) Programme Board** has also been established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the Charitable Funds Committee, and whilst is not a formal Sub-Committee of the Charitable Funds Committee, it is directly accountable to the Committee for its performance in exercising the functions set out in its formal Terms of Reference as part of good governance arrangements, which are formally approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the Charitable Funds Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board will be supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

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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)

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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
- Executive Director of Nursing, AHPs & Health ScienceDirector Velindre Cancer Service (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Senior Finance Business Partner
- Deputy Director of Finance

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- Head of Financial Planning & Reporting
- 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.

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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 Chair deems necessary - consistent with the Trust's annual plan of Board Business.

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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, Development 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.

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

2. PURPOSE

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

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

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

3. DELEGATED POWERS AND AUTHORITY

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

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

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

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

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

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

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

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

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- 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.

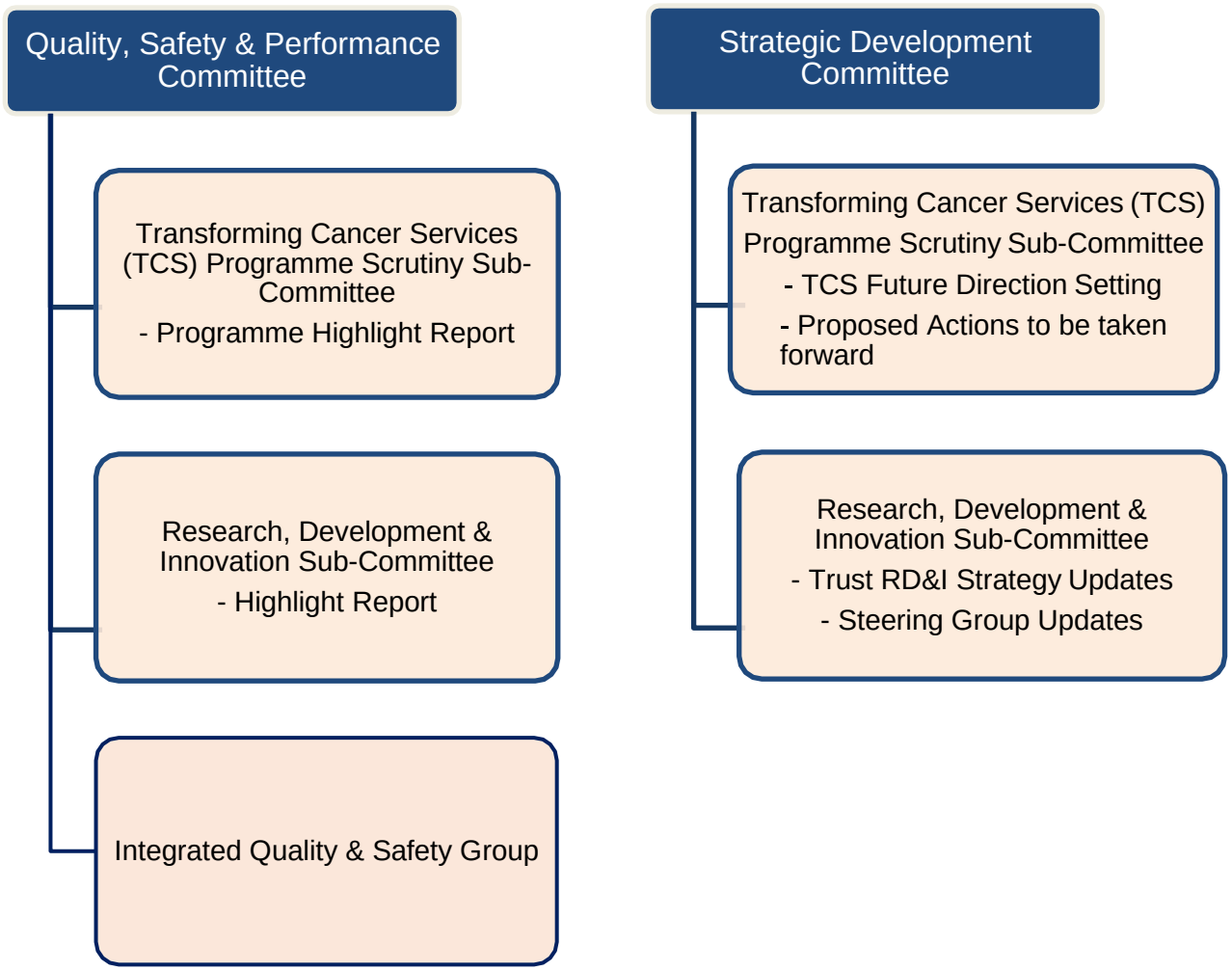
Sub Committees

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.

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

The two sub-committees 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
- Chief Digital Officer (*also cyber/data outtages/performance)*
- Quality & Safety Manager
- Head of Corporate Governance

4.3 By invitation

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

- Healthcare Inspectorate Wales
- Audit Wales

- Trade Unions
- Community Health Council

Secretariat

4.4 Secretary - as determined by the Director of Corporate Governance 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 organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

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

6.6 The Committee has approved the establishment of an Integrated Quality & Safety Group to support the Committee in effectively executing its responsibilities by undertaking quality and safety intelligence triangulation / analysis and learning assurance to facilitate enhanced efficiency of reporting to the Committee.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

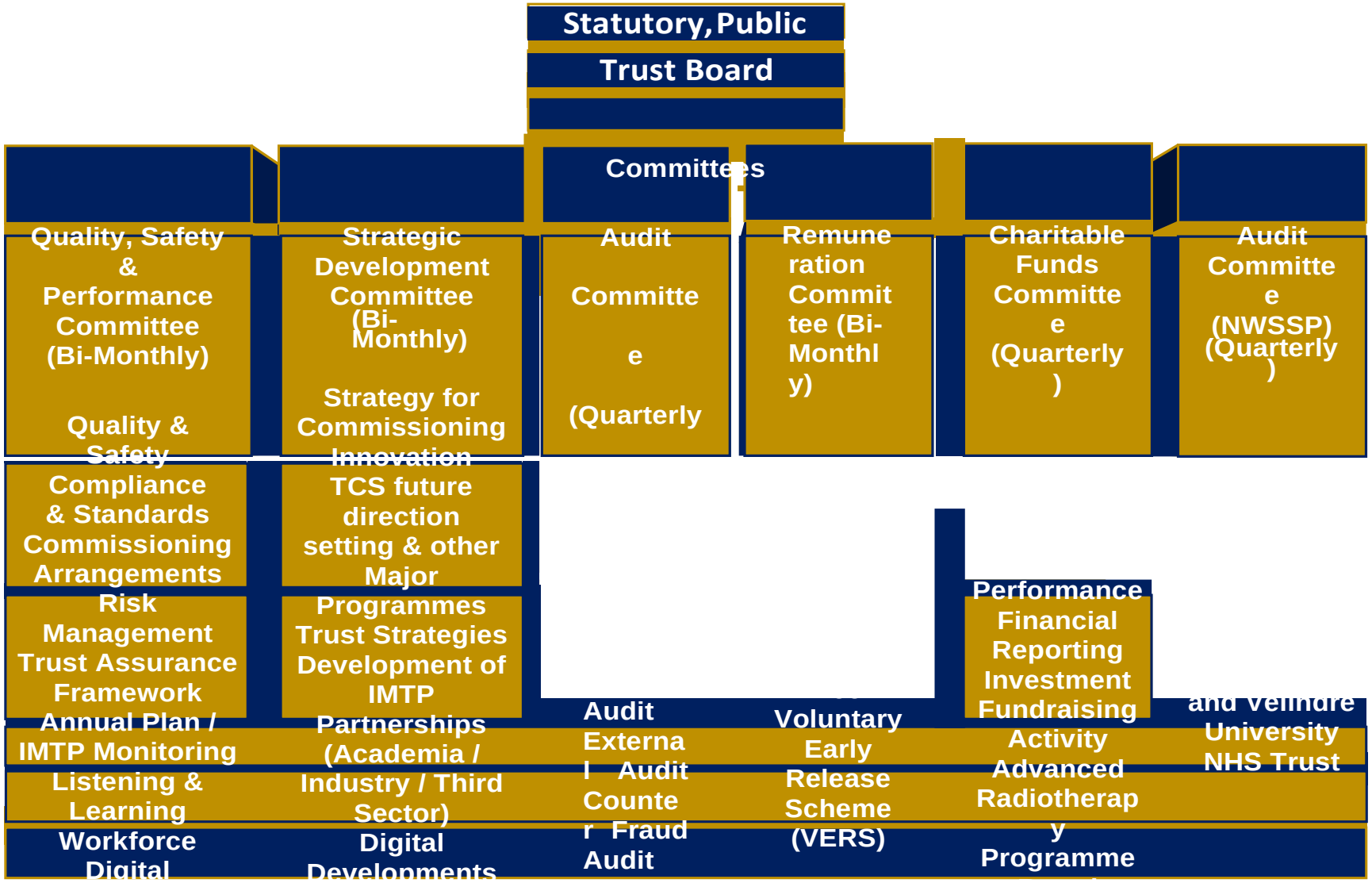
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

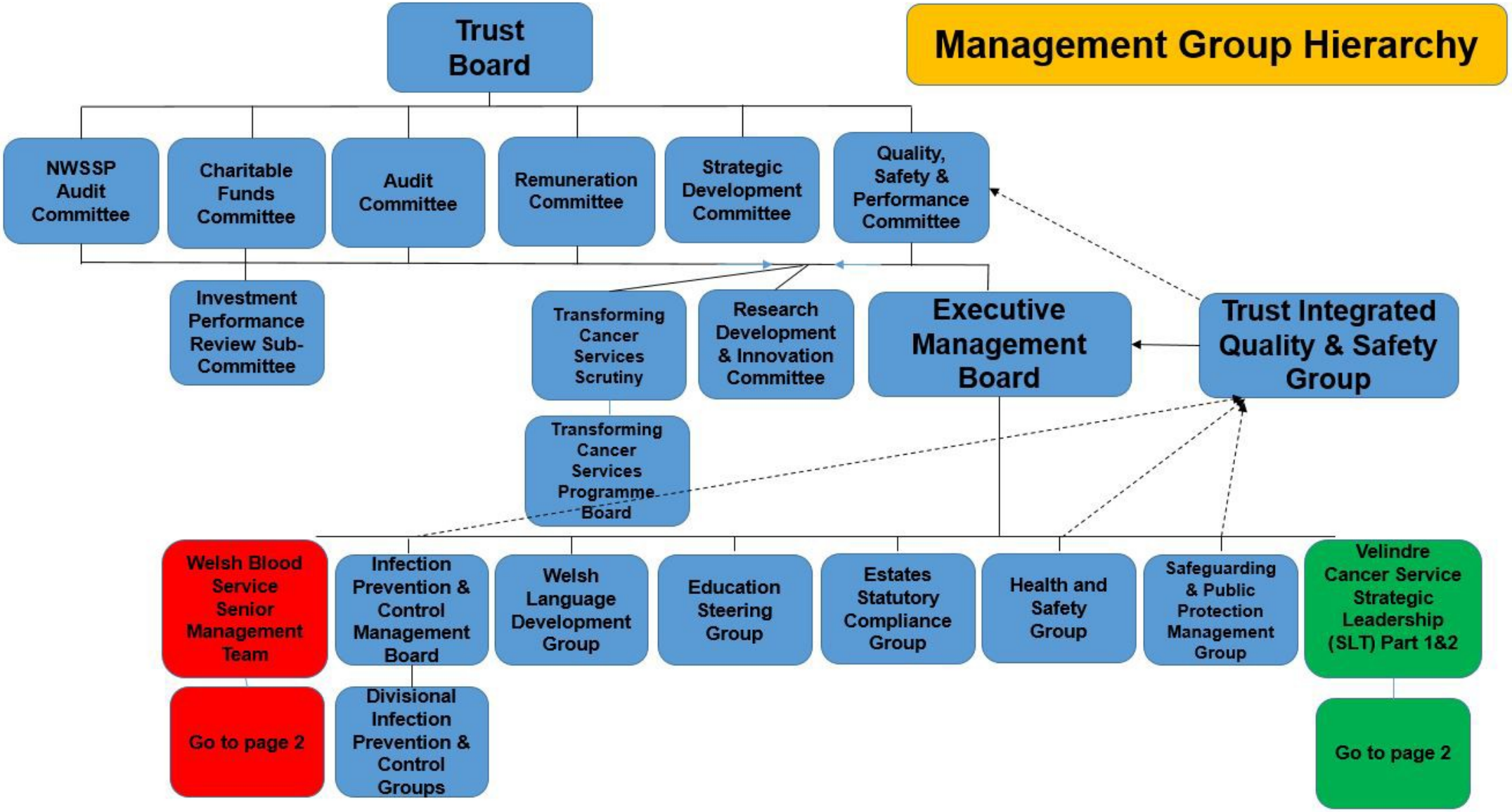
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf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

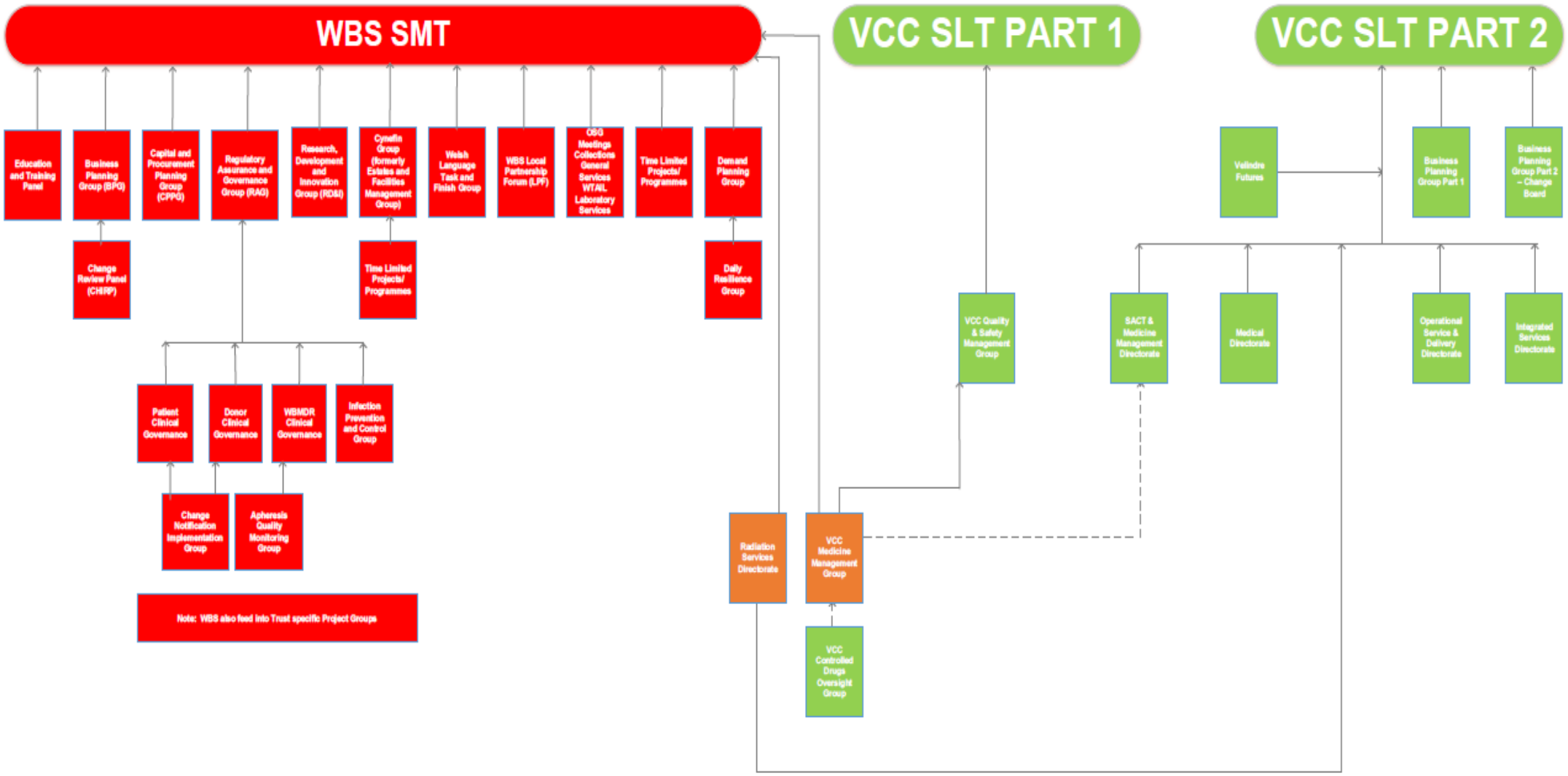
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK




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

Research, Development & Innovation (RD&I) Sub-Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
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.

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**

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.

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.

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

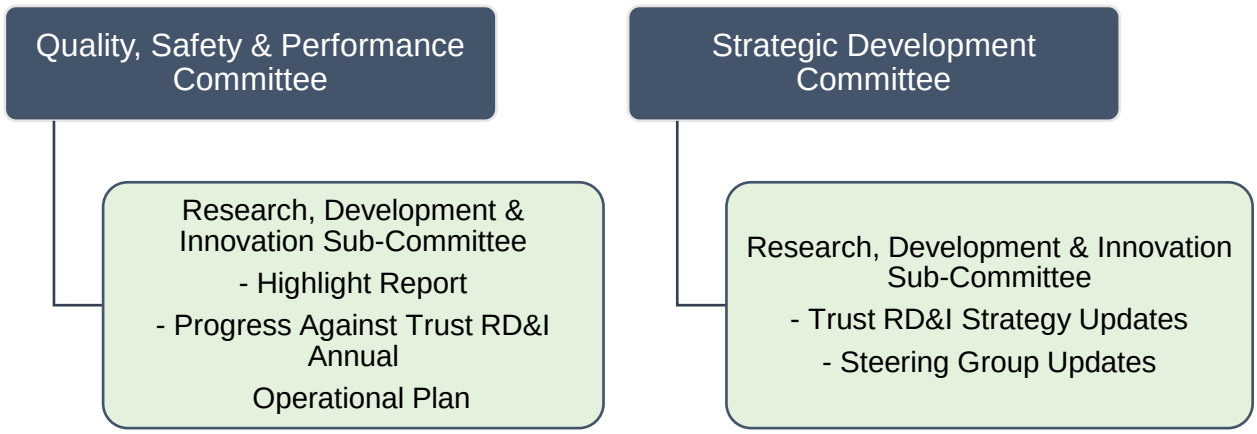
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. SUB-COMMITTEE MEETINGS

5.1 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.

6.4 The Sub-Committee is supported by the **Advancing Radiotherapy Fund (ARF) Programme Board,** established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the RD&I Sub-Committee that is subject to formal endorsement by the RD&I Sub-Committee prior to the formal approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the RD&I Sub-Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board is also supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 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

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

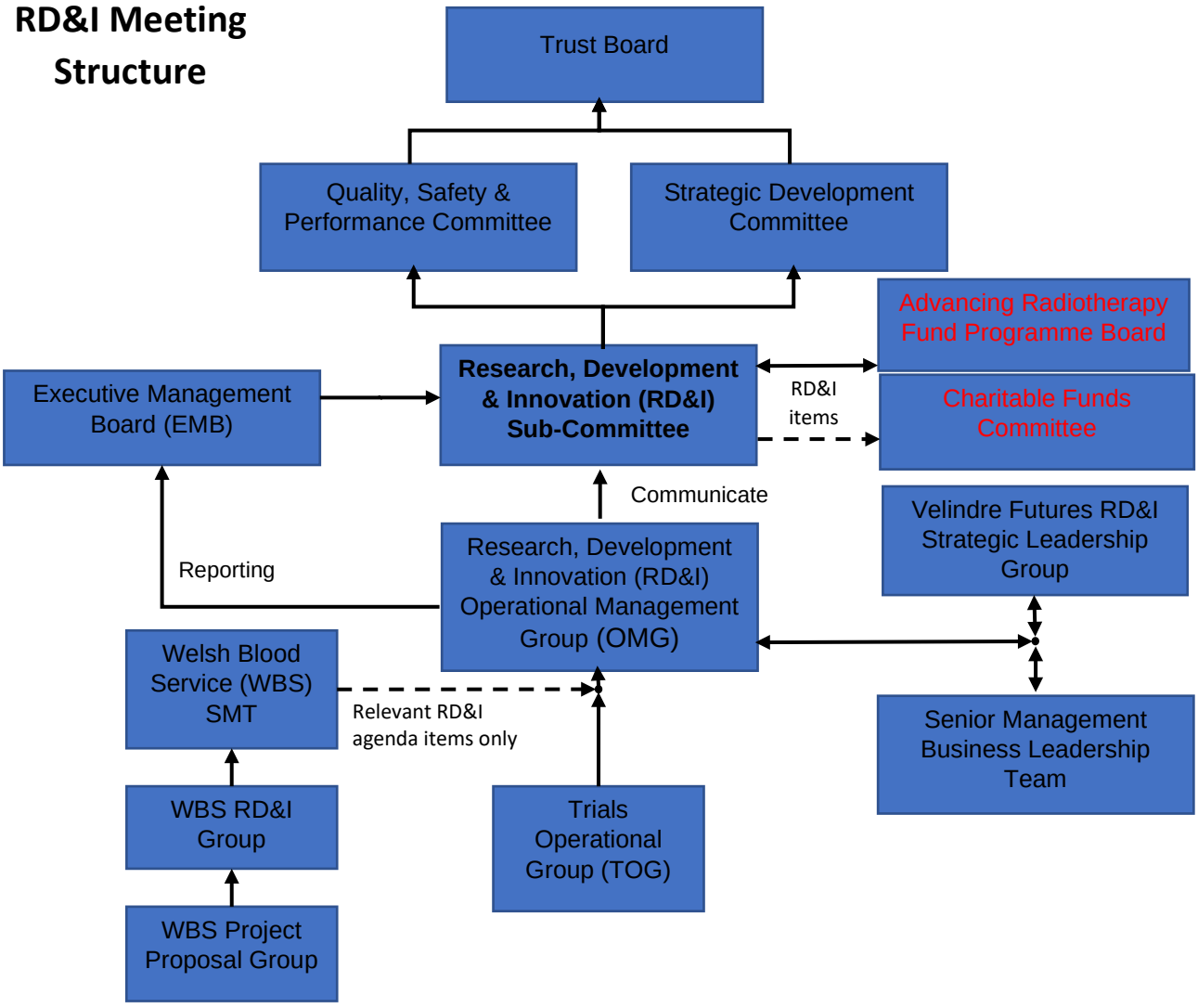
10. CHAIR'S ACTION ON URGENT MATTERS

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



Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2023
Approved:	
Next Review due:	March 2024

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 2021.
  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.

The **Advancing Radiotherapy Fund (ARF) Programme Board** has also been established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the Charitable Funds Committee, and whilst is not a formal Sub-Committee of the Charitable Funds Committee, it is directly accountable to the Committee for its performance in exercising the functions set out in its formal Terms of Reference as part of good governance arrangements, which are formally approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the Charitable Funds Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board will be supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

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
- Executive Director of Nursing, AHPs & Health ScienceDirector Velindre Cancer Service (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Senior Finance Business Partner

- Deputy Director of Finance
- Head of Financial Planning & Reporting
- 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 Chair 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, Development 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.