Public Audit Committee

Wed 26 July 2023, 09:30 - 13:30

Velindre UNHS Trust Headquarters

Agenda

09:30 - 09:50
20 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 25 April 2023

Led by Martin Veale, Chair of the Audit Committee

1.4.0 DRAFT MINUTES OF THE PART A PUBLIC AUDIT COMMITTEE 25 APRIL 2023- LFMV Final.pdf (9 pages)

1.5.0 Action Log

Led by Martin Veale, Chair of the Audit Committee

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

09:50 - 10:30
40 min

2.0.0 EXTERNAL AUDIT

Led by Steve Wyndham and Katrina Febry (Audit Wales)

2.1.0 Final Audit Plan

Led by Steve Wyndham and Katrina Febry (Audit Wales)

2.1.0 3653A2023_VUNHST_Detailed_Audit_Plan_2023_Eng.pdf (20 pages)

2.2.0 Audit Position Update

Led by Steve Wyndham and Katrina Febry (Audit Wales)

- **Appendix - Good Practice Exchange**

2.2.0a VUNHST Audit Cmt 20230712 Audit Update.pdf (10 pages)
2.2.0b VUNHST Audit Cmt 20230712 Audit Update appendix.pdf (7 pages)

2.3.0 Public Sector Readiness for Net Zero Carbon by 2030 - Management Responses

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

2.3.0a Call to Action Cover Paper v0.2 27.06.2023.pdf (3 pages)
2.3.0b Appendix 1 - Audit Wales Response v1.1.pdf (12 pages)

10:30 - 11:00
30 min

3.0.0 CONFIRMED FINAL ACCOUNTS - ACCOUNTABILITY REPORT & ANNUAL ACCOUNTS 2022-23

3.1.0 Cover Paper for Accountability Report & Annual Accounts 2022-23

Led by Emma Stephens, Head of Corporate Governance and Chris Moreton, Deputy Director of Finance

3.1.0 Accountability Report & Annual Accounts - Cover Report July 2023.pdf (8 pages)

3.2.0 Accountability Report for 2022-23

Led by Emma Stephens, Head of Corporate Governance

To Note – In relation to Financial Accountability, a section will be added at a later date which is currently under review.

3.2.0 Final Draft - Accountability Report_2022-23.pdf (107 pages)

3.2.0A Velindre University NHS Trust Final Accounts 2022-23

Led by Chris Moreton, Deputy Director of Finance

3.2.0A Velindre University NHS Trust Final Accounts 2022-23 FINAL.pdf (83 pages)

3.2.0Bi Appendix 1 - Letter of Representation 2022-23

Led by Matthew Bunce, Executive Director of Finance

3.2.0bi Appendix 1 - letter of representation.pdf (3 pages)

3.2.0Bii Appendix 2 - Audit Wales Governance Statements Factsheet and Observations

Led by Chris Moreton, Deputy Director of Finance and Emma Stephens, Head of Corporate Governance

3.2.0Bii Audit-Enquiries-Letter-2022-23 FINAL.pdf (19 pages)

11:00 - 11:30
30 min

4.0.0 CONFIRMED FINAL ACCOUNTS - AUDIT WALES – AUDIT OF FINANCIAL STATEMENTS

Led by Steve Wyndham (Audit Wales)

4.1.0A AUDIT WALES ISA 260 REPORT

Led by Steve Wyndham (Audit Wales)

4.1.0a Audit of Accounts Report - VUNHST - 22-23_.pdf (18 pages)
4.1.0 Covering paper ISA 260 July 23.pdf (3 pages)

11:30 - 11:50
20 min

5.0.0 PRIVATE PATIENT SERVICE REVIEW

Led by Matthew Bunce, Executive Director of Finance

5.1.0 Actions Update Report

Led by Matthew Bunce, Executive Director of Finance

5.1.0 Audit Committee Private Patient Report Jul'23.pdf (6 pages)
5.1.0a PP Action Plan 170523.pdf (3 pages)

11:50 - 12:00
10 min

6.0.0 VUNHST CLINICAL AUDIT ANNUAL REPORT 2021-2023

Led by Zoe Gibson, Interim Head of Quality Safety and Assurance

- 6.0.0a Trust Clinical Audit Annual Report 2021-2023 Cover Report to Audit Committee 26.07.23.pdf (7 pages)
- 6.0.0b VUHNST CLINICAL AUDIT ANNUAL REPORT 2021-23 Final V6.pdf (117 pages)

12:00 - 12:35
35 min

7.0.0 INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING

7.1.0 Trust Risk Register

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

- 7.1.0a RR - AUDIT -Trust Risk Register - 26.07.2023- V02.pdf (9 pages)
- 7.1.0b APPENDIX 1 - RISK REGISTER - 18.07.2023 -V05.pdf (12 pages)
- 7.1.0c APPENDIX 2 - Overall Risk Data - 18.07.2023.pdf (2 pages)

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

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

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

Led by Matthew Bunce, Executive Director of Finance

- 7.3.0a Audit Action Tracker Cover Paper 26 July 2023 Audit Committee.pdf (13 pages)
- 7.3.0b Appendix 1 - Red Overdue Recommendations Actions.pdf (2 pages)
- 7.3.0c Appendix 2 - Audit Action Tracker - Updated June 2023 - 29 June 2023 Audit Committee Overdue_Red and Complete_Green.pdf (17 pages)

12:35 - 12:50
15 min

8.0.0 INTERNAL AUDIT

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

8.1.0 2022/23 Final Annual Report & Head of Internal Audit Opinion

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

- 8.1.0a VT 2223 Annual Internal Audit Opinion - Cover Paper (AC).pdf (5 pages)
- 8.1.0b VT 22-23 HIA Annual Report and Opinion.pdf (25 pages)

8.2.0 2023/24 Internal Audit Progress Update

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

- 8.2.0a VT 2324 Internal Audit Progress Report - Cover Paper.pdf (6 pages)
- 8.2.0b VT 2324 Audit Committee Progress Report - Jul-23.pdf (6 pages)

12:50 - 13:00
10 min

9.0.0 COUNTER FRAUD

9.1.0 Counter Fraud Progress Report Quarter 1 23/24

Led by Gareth Lavington, Lead Local Counter Fraud Specialist

- 9.1.0a Board Committee Report Cover Sheet Public.pdf (8 pages)
- 9.1.0b VELINDRE Q1 COUNTER FRAUD PROGRESS REPORT - PUBLIC.pdf (13 pages)
- 9.1.0c APPENDIX 3 PUBLIC Supplementary - NHSCFA THEMATIC EXERCISE.pdf (16 pages)

13:00 - 13:15

10.0.0 FINANCE

15 min

10.1.0 Private Patient Service Debt Position

Led by Rachel Hennessy, Head of Operations and Service Delivery Deputy Director and David Osborne Head of Finance Business Partnering

10.1.0 Audit Committee - Aged Debt Private Patient Service July 23.pdf (7 pages)

10.2.0 Losses and Special Payments Report

Led by Chris Moreton, Deputy Director of Finance

10.2.0 Losses and Special Payments_Audit Committe_July 2023.pdf (3 pages)

13:15 - 13:30
15 min

11.0.0 CONSENT AGENDA

Led by Martin Veale, Chair of the Audit Committee

11.1.0 ENDORSE FOR APPRVAL

Led by Martin Veale, Chair of the Audit Committee

11.1.1 Variation to Standing Orders Velindre University NHS Trust

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

11.1.1a Revisions to Trust Model Standing Orders_Audit Committee_July 2023_Cover Report v2.pdf (7 pages)
11.1.1b Appendix 1 - NHS Trusts Model Standing Orders, Reservation and Delegation of Powers - June 2023 v6 0.1 Draft for agreement.pdf (78 pages)

11.2.0 FOR APPROVAL

Led by Martin Veale, Chair of the Audit Committee

11.2.1 Financial Control Procedure Update

Led by Matthew Bunce, Executive Director of Finance

- **FCP 1 – Budgetary Control procedure**

11.2.1a - FCP Cover Paper Audit Committee.pdf (7 pages)
11.2.1b Appendix 1 - FCP 1 Budgetary control procedure Update June 23.pdf (11 pages)

11.2.2 Chairs Urgent Action

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

- **Audit Action Tracker - Closure of the nine Complete (Green Status) Actions formally Closed (Blue Status)**

11.2.2a Cover Paper Chairs Urgent Action - Audit Committee 26 July 2023.pdf (6 pages)
11.2.2b Appendix 1 Audit Action tracker - 9 Blue Status Update May 2023 Actions.pdf (3 pages)

11.3.0 FOR NOTING

Led by Martin Veale, Chair of the Audit Committee

11.3.1 Procurement Compliance Report

Led by Matthew Bunce, Executive Director of Finance

11.3.1 Procurement Report to June 23 19.07.23.pdf (15 pages)

11.3.2 Follow Up of Previous Recommendations

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

- 11.3.2a VT 2223-14 IAReport Cover Paper - Follow Up.pdf (5 pages)
- 11.3.2b VT 2223-14 Final Internal Audit Report - Follow Up.pdf (6 pages)

11.3.3 Trust Priorities

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

- 11.3.3a VT 2223-07 IA Report Cover Paper - Trust Priorities.pdf (5 pages)
- 11.3.3b VT 2223-07 Final Internal Audit Report - Trust Priorities.pdf (13 pages)

11.3.4 Audit Committee Cycle of Business

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

- 11.3.4a Audit Committee Cycle of Business 2023-2024 Cover Paper.docx v2.pdf (5 pages)
- 11.3.4b Appendix 1 Audit Committee annual plan 2023 2024 Draft.pdf (1 pages)

13:30 - 13:30
0 min

12.0.0 HIGHLIGHT REPORT TO THE TRUST BOARD

13:30 - 13:30
0 min

13.0.0 MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS

13:30 - 13:30
0 min

14.0.0 ANY OTHER BUSINESS

13:30 - 13:30
0 min

15.0.0 DATE AND TIME OF THE NEXT MEETING

Thursday 05 October 2023 at 10:00AM

13:30 - 13:30
0 min

16.0.0 CLOSE

MINUTES OF THE PUBLIC AUDIT COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
TUESDAY 25 APRIL 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
Claire Bowden	Head of Financial Operations
Simon Cookson	Director of Audit & Assurance (NWSSP - Audit and Assurance Services)
Emma Rees	Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services)
Melanie Goodman	Audit Manager (NWSSP - Audit and Assurance Services)
Katrina Febry	Audit Wales
Steve Wyndham	Audit Wales
Gareth Lavington	Lead Local Counter Fraud Specialist
Alison Hedges	Business Support Officer

1.0.0	**Standard Business** Led by Martin Veale, Chair, and Independent Member	**Action**
	Introduction Led by Martin Veale, Chair, and Independent Member Martin Veale expressed concern at the length of the papers provided to the committee, which ran to 509 pages, which excluded the Private Audit Committee which follows. He also stated that four papers were not available until the day of the meeting: two (on the governance workstream of Building our Future Together and on net zero) were postponed until the July meeting of the committee; and the remaining two items would be presented as oral updates. Concern was also expressed regarding the length of the minutes of the last meeting, and the committee requested that minutes should provide a summary of discussions.	
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 • Richard Harries, Audit Wales • Darren Griffiths, Audit Wales • Helen James, Head of Procurement • Felicity Quance, Deputy Head of Internal Audit	
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.	
1.3.0	**Declarations of Interest** Led by Martin Veale, Chair, and Independent Member No declarations of interest were declared.	
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 ****ACTION: Change Page 6 "*Quality Government*" to "*Quality Governance*".**	**AH**

	The AUDIT Committee **AGREED** the minutes of the meeting held on the 12 January 2023 subject to the minor noted amendment.	
1.5.0	**Action Log** Led by Martin Veale, Chair, and Independent Member **07/2022 2.2.1 Procurement Compliance Report – Procurement Framework Agreement Review** – A procurement surgery has been organised at the Velindre Cancer Centre on 3 May 2023. An ongoing training programme and communications are in place to help raise awareness. The AUDIT Committee **AGREED** and **NOTED** all the **CLOSED** actions. **05/2022 6.6.0 Internal Audit Report: DBS Checks –** Closed Action - Vicky Morris wanted to raise to the Audit Committee the process for agreeing policies and highlighted that the DBS policy hasn't been brought back to the Quality Safety and Performance Committee. ***ACTION: Lauren Fear to check and clarify the procedure in relation to policies and the process before going for Board approval.**	**LF**
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 The committee was reminded that commercial and financial actions are brought to the Audit Committee to review and consider in terms of progress whilst the others are provided to the Quality Safety and Performance Committee. Matthew Bunce assured the Committee that there were no new issues to alert and escalate. Liaison services (experts in the field of private patients) have been working with Velindre since December 2022, and are currently reviewing tariffs, and have also completed the preparation work to start negotiation with the three main insurance contractors and the Finance team will attend meetings to ensure learning. Matthew Bunce noted that the deadline target date for work on the contracts with the insurers is June 2023 (the wrong date is in the paper). Matthew Bunce flagged the following points on the Appendix – Action Plan, on the Quality Safety and Performance there are four that were raised in the last Audit Committee and these have been flagged with the team as Matthew Bunce believes these should be closed. Matthew Bunce explained there are extensions that have been requested for some actions. ****ACTION: Matthew Bunce to ask the Working Group to add an action to ask for a summary report from Liaison on the outputs of their work with the Trust** Gareth Jones requested assurance that invoices were raised promptly and that payment was chased, but Matthew Bunce confirmed that this was still an issue due to vacancies and sickness. Vicky Morris expressed concern about commentary in the outcome column of the table which didn't provide assurance or clarity. Cath O'Brien gave assurance that operationally there have been discussions and the team are looking at the need to recognise there is a small team and there will be vulnerability, so there is a need to have better cross cover and resilience in the future. The AUDIT Committee **NOTED** the report, **APPROVED** the amended Private Patient Improvement Plan, and **AGREED** to oversee the implementation of the financial and commercial improvements.	**MB**
	Cath O'Brien left the meeting at 10:30AM during item 2.1.0 and re-joined at 10:44AM during item 3.3.0.	
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 Lauren Fear informed the Committee that the latest version of the Trust Risk Register was presented to Quality Safety and Performance Committee and Trust Board in March 2023. An updated version of the register will go to Executive Management Board, Quality Safety and Performance Committee and then to Trust Board in May 2023. Lauren Fear highlighted that there was a meeting held on 16 March 2023 with Audit Committee members where a version of an updated template was used following feedback from Audit Committee and Quality Safety and Performance Committee. There was further feedback at the March Trust Board meeting. Lauren Fear informed the Committee that the risks are being reviewed with input across the Leadership Teams from the divisions, as well as Executive Management Board, and that the next Strategic Development Committee is scheduled to have a discussion on the overall view of strategic risk. The relevant risks will be reviewed to each Committee and then be brought back to Trust Board. This will come to Audit Committee as a substantial paper in July 2023. Vicky Morris highlighted that it picks up some of the Governance Reports from Audit to be able to demonstrate what's changed so Independent Members can pose questions in terms of seeking assurance. In response to a question, Lauren Fear confirmed that the format is going to be used consistently across the Board and its committees. The AUDIT Committee **NOTED** the oral update on the Trust Risk Register.	
3.2.0	**Trust Assurance Framework (Oral Update)** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear told the Committee that in the 16 March 2023 meeting with Audit Committee member, the template for the Trust Assurance Framework was reviewed. Further feedback was provided at the March Trust Board meeting. Vicky Morris noted that the Quality Safety and Performance Committee had previously noted some gaps in controls and assurances, and that QSP was going to do a deep dive into various sections that are relevant to that committee. The AUDIT Committee **NOTED** the oral update on the Trust Assurance Framework.	
3.3.0	**Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce took the Committee through the Audit Action Tracker Report. The committee expressed concern that some actions hadn't been updated for some time, and that it appeared that a worryingly high number (18%) of management actions are not complete. By way of assurance Simon Cookson informed the committee that he thought Velindre was broadly in line with other NHS Wales organisations in completing outstanding audit actions. The committee queried whether there should be a cut off point for the long outstanding recommendations. Katrina Febry commented that she thought there has been progress in relation to recommendations where there use to be discrepancy between Audit Wales and the Trust as to what was thought to be an acceptable recommendation. This now has more alignment and Audit Wales are planning to spend more time following up on recommendations. ****ACTION: Matthew Bunce agreed with the Committee that Section 2.2.2 updates to reflect the internal audit report table will be removed from the Cover Paper Report going forward.**	**MB and AH**

	****ACTION: Matthew Bunce agreed with the Committee to stop including the previous information as a comparison for internal and external recommendations.** ****ACTION: The Committee raised the need to keep the paper up to date to save confusion and to remove the dates that have no reports outstanding within them on the tables.** ****ACTION: Following discussion on the outstanding TCS nVCC actions the Committee agreed that these could be taken offline and agreed out of Committee.** **Alison Hedges to send the TCS sections to Matthew Bunce and Lauren Fear to review and provide feedback to be considered in an email out of Committee.** Following discussion it was agreed that the 7 levels assurance would be in the cover paper in terms of the effectiveness of the actions and suggested this could be achieved by splitting out the assessment into key themes. ****ACTION: The Committee agreed and that the conversation on the 7 levels of assurance could be taken offline and would be aligned in Executive Management Board.** The AUDIT Committee: **NOTED** the contents of the report and the action on target (Yellow Status). **APPROVED**: • 40 Internal Audit and 18 External Audit report actions (Green Status) be formally Closed (Blue Status). • 13 Internal Audit and 1 External Audit report actions that have passed the agreed implementation date (Red Status). • The extension dates identified on the basis that we keep a track of these on the Audit Action Tracker and these be referenced on the Tracker going forward.	**MB and AH** **MB and AH** **AH,MB and LF** **MB**
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 Matthew Bunce explained this protocol had developed after various meetings involving Andy Butler and Jonathan Irvine, and that the key point is the important change to the last paragraph line starting 'NWSSP Procurement Services will subsequently provide Velindre University NHS Trust with the outcome of the risk assessment received'. Gareth Jones noted that the protocol was still in draft. He thought that the phrase "may, where considered necessary, seek and obtain a legal counsel risk assessment" needed strengthening, and was uncomfortable with the discretion of whether to obtain a legal risk review sits entirely with shared services when it is potentially Velindre that will be facing the consequences would like more impact into that decision. ****ACTION: The Procurement Protocol discussion will be taken offline and a form of different wording will be agreed with Andy Butler and Jonathan Irvine. This will then be brought to the July Audit Committee on the consent agenda.**	**MB, GJ and MV**
4.0.0	**EXTERNAL AUDIT** Led by Steve Wyndham and Katrina Febry (Audit Wales)	
4.1.0	**Auditor General for Wales NHS – Audit of Accounts 2022-23 letters** Led by Steve Wyndham (Audit Wales) Steve Wyndham explained that the letters from Audit Wales convey the delay to the audit process experienced last year and sets out the revised audit timing for this year with the circumstances behind that. Steve Wyndham thanked the Trust for understanding and accommodating these dates. Claire Bowden reassured the Committee the timetable is achievable and work will be completed. Draft accounts are due 5 May 2023 and then will work toward the Audit. The Draft Annual Governance Statement due 12 May 2023. Steve Wyndham informed the Committee that he can't complete until mid-July but majority of the work will be done before.	

	Gareth Jones queried the section of the second letter which refers to "there is an increase of 15% in the audit fee and that is just an initial estimate", and asked for assurance that this figure would not be exceeded. In response Steve Wyndham stated that 15% is a guideline, and that planning work and risk assessment was still ongoing. ****ACTION: Claire Bowden to share draft accounts with Martin Veale, Vicky Morris, and Gareth Jones 9 May 2023.** The AUDIT Committee **NOTED** the letters.	**CB**
4.2.0	**Audit Plan** Led by Steve Wyndham and Katrina Febry (Audit Wales) Steve Wyndham stated that they were unable to bring an actual audit plan and will bring one to July 2023 meeting but will circulate to management and committee members prior to then. He outlined two key matters. Firstly, there is continuity in the audit team with the only change being the Financial Audit Engagement Lead, Richard Harries, who is replacing Clare James. The second matter is in relation to audit timelines, confirming working to a July audit deadline. Performance Audit – Katrina Febry informed the committee that they will be conducting audits on structured assessment, a deep dive into a specific thematic area and another to be decided; stating that one area that could be looked at is the Well-being of Future Generations Act setting of objectives and could potentially look at Board and Committees and the interconnection from divisions through into Executive Management Board. Lauren Fear commented that it may be useful for Katrina Febry to attend Executive Management Board. ****ACTION: Alison Hedges to liaise with Melanie Findlay to get an invite to Katrina to attend an EMB Run that suits as it would be useful for them to be aware of the Audit Wales Audit Plan.** The AUDIT Committee **NOTED** the Audit Plan.	**AH**
4.3.0	**Audit Position Update** Led by Steve Wyndham and Katrina Febry (Audit Wales) Katrina Febry informed the Committee this was a summary of where Audit Wales are with the work from the 2022/23 Plan. Katrina Febry informed there are two performance pieces of work outstanding one on Workforce planning where the work is in progress. Katrina Febry proposed the small pot of budget from 2022/23 plan be considered alongside the 2023/24 Plan. The AUDIT Committee **NOTED** the report.	
4.4.0	**Annual Audit Report** Led by Katrina Febry (Audit Wales) Financial Audit – Steve Wyndham highlighted the unqualified opinion on the 2021/22 accounts, with no significant control weaknesses identified. However, he noted that whilst the Auditor General did not qualify the financial accounts, he did qualify the regularity opinion on the Trust. Steve Wyndham noted to the Committee that this was a Wales-wide NHS audit issue and outside the control of the Trust, resulting from a ministerial direction in regard to clinician's tax liabilities and how its accounted for within the financial statements. Martin Veale stated that paragraph 13 doesn't say this qualification of the regularity opinion was in line with every other NHS body and he found that disappointing. Performance – Katrina Febry highlighted that in relation to quality governance, significant progress had been made but wanted to draw attention to getting to the point where there's good	

	information in the Trust Risk Register and the Trust Assurance Framework to enable a better enhanced scrutiny of the risks. The AUDIT Committee **NOTED** the report.	
4.5.0	**Structured Assessment Report** Led by Katrina Febry (Audit Wales) Katrina Febry informed the Committee this was a positive report, with the overall message that "the Trust is generally well led and governed". She highlighted an area of good progress: on how the Trust sets actions for delivery in the IMTP and other plans, and making sure the intended impact of those actions are also set out and how that will be measured to enable effective scrutiny. Katrina Febry stated as long as the Committee were content Audit Wales could now move the report to final and publish it on the website. The AUDIT Committee **NOTED** the report.	
	The AUDIT Committee took a break at 11:45PM and resumed the meeting at 12:00PM.	
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 Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Emma Rees explained to the committee that as set out in the report there are five audits left to be delivered. Emma Rees highlighted that there has been good engagement during panning and fieldwork, but would like to see improvement in the time taken for management to respond, and to meet the 15 working day deadline. Emma Rees informed the Committee that it was agreed following the last meeting between Martin Veale, Matthew Bunce. Simon Cookson and Emma Rees that substantial and reasonable reports that didn't contain any high priority recommendation could in general go on consent agenda. The committee noted that the new format summary and charts were immensely helpful. Martin Veale agreed the timeliness of management responses will be included in the Highlight Report. The AUDIT Committee **NOTED** the report.	
5.2.0	**2023/2024 Internal Audit Plan** Led by Simon Cookson, Director of Audit & Assurance (NWSSP - Audit and Assurance Services) Simon Cookson highlighted that Internal Audit met with Executive Directors as part of the planning process, considered result of previous audits, appropriate documentation, and met with Audit Wales. He has proposed areas of work which link back to Trust Assurance Framework and the Trust Risk Register. Separately, work is being done around the new Velindre Cancer Centre in terms of the Integrated Audit and Assurance Plan and any relevant documents from this will be presented to a future Audit Committee meeting. Simon Cookson confirmed he will remain Director of Audit & Assurance, seeing through the year end and starting the programme for this year. He confirmed there is sufficient capacity in the teams for this work to be completed. The AUDIT Committee **APPROVED** the 2023/24 Internal Audit Plan and the Internal Audit Charter and as a requirement to the standards **NOTED** section 5 of the plan around resources, informing the Committee resources are available to undertake the plan that's being agreed.	

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 Gareth Lavington highlighted that the team completed 108 days in total for the year (38 days in that quarter) which is two days short of what was planned for. There have been a couple of short and resource-light investigations: one in relation to suspected theft of morphine at Velindre Cancer Centre, reported as an anonymous intelligence report to National Fraud Line where there were no issues found; and one in relation to a cloned credit card, which has now been refunded, the cloning dealt with and reported to Action Fraud. The National Fraud Initiative has now gone live and an appendix on this will be added for future meetings. The AUDIT Committee **RECEIVED** and **DISCUSSED** the report.	
6.2.0	**Annual Report 22/23** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Jones noted the high level of compliance in the report, and the amber rating for risk assessment. The AUDIT Committee **NOTED** the report.	
6.3.0	**Annual Plan 23/24** Led by Gareth Lavington, Lead Local Counter Fraud Specialist Gareth Lavington highlighted the workplan moving forward is very flexible, and dynamic so can adjust work through the year as necessary and breaks down how will comply with the NHS requirements. He stated that he is looking to improve proactive work for the organisation with regards to the eLearning awareness, risk assessments – these risk assessments will inform future workplans. Matthew Bunce informed the committee he has had discussions with Workforce team on inductions of new staff and they are looking to do more face-to-face meetings which include counter fraud and Information Governance. An eLearning module for counter fraud been developed over the past 12 months, whether this is mandatory will be down to individual organisations. Gareth Lavington confirmed this went live last Thursday and he has a meeting 26 April 2023 regarding pushing Communications out. ****ACTION: Martin Veale asked that Committee members be included in that Communication on the Counter Fraud Induction Programme and eLearning module to see how things progress.** The AUDIT Committee **NOTED** the report.	**GL**
7.0.0	**FINANCE**	
7.1.0	**Private Patient Service Debt Position** Led by Matthew Bunce, Executive Director of Finance Matthew Bunce noted again the challenges with consistent resourcing for this work. There has been a reduction in the time taken to invoice compared to earlier in the year, and Liaison have been trying to support. The Table under section 2.6 are the Key Performance Indicators that the Audit Committee were happy to approve in a previous meeting. Martin Veale highlighted the debts 30 days or less are quite low. Matthew Bunce confirmed work is ongoing, but that the volume of bills going out each month varies and could affect the percentage figures; billing happens when there is capacity to do so. Matthew Bunce highlighted in section 2.6 there is a suggestion for an additional indicator for debts recovered in month end.	

	Cath O'Brien provided assurance recruitment is underway and taking forward within the team where business continuity can be developed within the organisation to make sure there is more resilience. ****ACTION: Seek update from Dave Osbourne and ask to attend next meeting to talk to the paper and to provide further detail of the work in the Working Group.** The AUDIT Committee **REVIEWED** the Key Performance Indicators and **NOTED** the report.	**MB**
7.2.0	**Losses and Special Payments Report** Led by Claire Bowden, Head of Financial Operations Claire Bowden explained the paper summarises the write-offs that were reported in year. Only write offs processed this year were debts related to NHS England, which were reported verbally in July 2022. The value of the four debts was £39,960 and were for organisations that no longer exist so were unable to recover the debts. ****ACTION: Claire Bowden to remove the £000 at the top of each column as this indicated that the values below were in thousands.** In year had an abandoned claim for legal costs that Welsh Government agreed to the write off for £337,000. The AUDIT Committee **REVIEWED** and **NOTED** the report.	**CB**
8.0.0	**CONSENT AGENDA**	
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 The AUDIT Committee **NOTED** the report	
8.1.2	**Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Martin Veale asked whether the list of declarations of interest was a complete list as it seemed some key employments were missing. Lauren Fear responded that the list should be a complete picture and that she will confirm on this back to the Committee. The AUDIT Committee **NOTED** the report.	
	Gareth Jones left the meeting at 12:48PM	
8.1.3	**Clinical Audit Report** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) Following a query from Vicky Morris, Emma Rees confirmed the report was on the agenda for Quality, Safety and Performance. The AUDIT Committee **NOTED** the report.	
8.1.4	**Clinical Audit All-Wales Analysis Audit Report** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) The AUDIT Committee **NOTED** the report	
8.1.5	**Information Governance Final Internal Audit Report** Led by Emma Rees, Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) The AUDIT Committee **NOTED** the report	
8.1.6	**Capital Systems Audit Report** Led by Melanie Goodman, Audit Manager (NWSSP - Audit and Assurance Services) The AUDIT Committee **NOTED** the report	
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 The AUDIT Committee **ENDORSED** the report for Board approval.	
9.0.0	**HIGHLIGHT REPORT TO THE TRUST BOARD**	
	It was agreed by the Committee that a Highlight Report to the Trust Board would be prepared in readiness for its meeting 30 May 2023.	
10.0.0	**MEETING REVIEW & FURTHER ASSURANCE REQUIREMENTS**	
	None.	
11.0.0	**ANY OTHER BUSINESS** Prior Agreement by the Chair Required	
	None.	
12.0.0	**DATE AND TIME OF NEXT MEETING**	
	Wednesday 26 July 2023 at 10:00AM	
13.0.0	**CLOSE**	
	The meeting CLOSED at 1:00PM.	

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM AUDIT COMMITTEE MEETINGS

MINUTE NUMBER	ACTION	Comments	Status	INITIALS
	Actions from 19 July 2022 Meeting			
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**	**CLOSED** **Update JUNE 2023:** No SQA recorded and two STA's reported this AC period. Workshop was held 19th May 2023 good attendance and positive feedback received. Procurement Surgery held at VCC 3rd May 23 good feedback also received and future surgeries to be arranged. **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	**HJ**

			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.	
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 JULY 2023:** Preliminary work has been carried out and draft fields created by BI colleagues, these fields have been tested. The BI product is now being built by the team.	**ES**
	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**	**CLOSED** **Update JULY 2023:** The letter takes precedence over the table. The letter is already part of the Standing orders and Standing Financial Instructions. Therefore, I propose no further action.	**MB**

01/2023 2.2.1	**Procurement Compliance Report** **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.**	**ACTION: Mathew Bunce**	**CLOSED** **Update JUNE 2023:** Highlight report on Procurement activity will be presented to Mathew Bunce on monthly basis going forward and will be part of the Procurement Compliance Report. **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 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 JULY 2023:** Further work required on definitions which will need to be agreed by PP improvement group. Issues in relation to sickness and resource to support. **Update APRIL 2023:** Proposed KPIs in draft. Ongoing discussions regarding resource to produce report as significant requests to BI and impact of DHCR limiting resource available.	**RH**

	Actions from 25 April 2023 Meeting			
04/2023 1.4.0	**Draft Minutes from the Public Part A Audit Committee meeting held on 12 January 2023** **ACTION: Change Page 6 "*Quality Government*" to "*Quality Governance"***	**ACTION: Alison Hedges**	**CLOSED** **Update MAY 2023:** The Minutes have been updated to read "Quality Governance".	**AH**
04/2023 1.5.0	**Action Log** **ACTION: Lauren Fear to check and clarify the procedure in relation to policies and the process before going for Board approval.**	**ACTION: Lauren Fear**	**CLOSED** **Update JULY 2023:** The flow chart in the policy explains the steps to be taken when considering the development of a Policy or Written Control Document. The policy highlights the importance of consultation in the development of policy before submission the appropriate Committee for approval. If there any issues that cannot be resolved at Committee level, the Policy will be brought to the Trust Board for final consideration and approval. The DBS procedure was approved by Safeguarding Group in September 2022 and EMB in January 2023	**LF**

			and has been live on the Recruitment toolkit page: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Attracting-and-Retaining-the-Best-Talent.aspx	
04/2023 2.1.0	**PRIVATE PATIENT SERVICE REVIEW Actions Update Report** **ACTION: Matthew Bunce to ask the Working Group to add an action to ask for a summary report from Liaison on the outputs of their work with the Trust.**	**ACTION: Matthew Bunce**	**CLOSED** **Update JULY 2023:** Working Group has agreed an action to produce an output summary report at the conclusion of work conducted with the Trust, planned at Aug 23.	**MB**
04/2023 3.3.0	**Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit** **ACTION: Matthew Bunce agreed with the Committee that Section 2.2.2 updates to reflect the internal audit report table will be removed from the Cover Paper Report going forward.**	**ACTION: Matthew Bunce and Alison Hedges**	**CLOSED** **Update MAY 2023:** Section 2.2.2 updates to reflect the internal audit report table was removed from the Cover Paper for May 2023 EMB and will not be included in any future Audit Action Tracker Cover Papers going forward.	**MB and AH**
04/2023 3.3.0	**Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit** **ACTION: Matthew Bunce agreed with the Committee to stop including the previous information as a comparison for internal and external recommendations.**	**ACTION: Matthew Bunce and Alison Hedges**	**CLOSED** **Update MAY 2023:** The previous information as a comparison for internal and external recommendations was removed from the Cover Paper for May 2023 EMB and will not be included in any future Audit Action Tracker Cover Papers going forward.	**MB and AH**

04/2023 3.3.0	**Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit** **ACTION: The Committee raised the need to keep the paper up to date to save confusion and to remove the dates that have no reports outstanding within them on the tables.**	**ACTION: Matthew Bunce and Alison Hedges**	**CLOSED** **Update MAY 2023:** The dates that have no reports with actions outstanding have been removed from the internal and external report table on the June 2023 EMB Cover Paper and these won't be included in these tables going forward.	**MB and AH**
04/2023 3.3.0	**Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit** **ACTION: Following discussion on the outstanding TCS nVCC actions the Committee agreed that these could be taken offline and agreed out of Committee. Alison Hedges to send the TCS sections to Matthew Bunce and Lauren Fear to review and provide feedback to be considered in an email out of Committee.**	**ACTION: Alison Hedges, Matthew Bunce and Lauren Fear**	**CLOSED** **Update MAY 2023:** Audit Action Tracker TCS Sections updates provided and agreed by David Powell and Mark Ash. These were circulated for out of committee approval 24 May 2023.	**AH, MB and LF**
04/2023 3.3.0	**Audit Action Tracker – Review of all outstanding audit actions from Internal & External Audit** **ACTION: The Committee agreed and that the conversation on the 7 levels of assurance could be taken offline and would be aligned in Executive Management Board.**	**ACTION: Matthew Bunce**	**CLOSED** **Update JUNE 2023:** The new 7 levels of assurance cover paper will be used going forward. This was applied to the paper taken to June 2023 EMB Run.	**MB**

04/2023 3.4.0	**Procurement Protocol - Notification of the Risk of Legal Challenge to the Award of All Wales Contracts Pursuant to the Public Contract Regulations 2015 (PCR 2015)** **ACTION: The Procurement Protocol discussion will be taken offline and a form of different wording will be agreed with Andy Butler and Jonathan Irvine. This will then be brought to the July Audit Committee on the consent agenda.**	**ACTION: Matthew Bunce, Gareth Jones, and Martin Veale**	**OPEN** **Update JUNE 2023:** Meeting arranged for 14 July 2023 to discuss Procurement Protocol.	**MB, GJ and MV**
04/2023 4.1.0	**EXTERNAL AUDIT** **Auditor General for Wales NHS – Audit of Accounts 2022-23 letters** **ACTION: Claire Bowden to share draft accounts with Martin Veale, Vicky Morris, and Gareth Jones 9 May 2023.**	**ACTION: Claire Bowden**	**CLOSED** **Update MAY 2023:** Copy of Draft Trust Accounts 2022/2023 shared with Martin Veale, Vicky Morris, and Gareth Jones 15/05/2023.	**CB**
04/2023 4.2.0	**EXTERNAL AUDIT** **ACTION: Alison Hedges to liaise with Melanie Findlay to get an invite to Katrina to attend an EMB Run that suits as it would be useful for them to be aware of the Audit Wales Audit Plan.**	**ACTION: Alison Hedges**	**CLOSED** **Update JUNE 2023:** The Audit Plan is being brought to 30 June 2023 EMB Run.	**AH**
04/2023 6.3.0	**COUNTER FRAUD** **Annual Plan 23/24** **ACTION: Martin Veale asked that Committee members be included in that Communication on the Counter Fraud Induction Programme and eLearning module to see how things progress.**	**ACTION: Gareth Lavington**	**CLOSED** **Update MAY 2023:** Martin Veale, along with other Audit Chairs and DoF's was emailed with the communication document in relation to this on the 26/04/2023.	**GL**

04/2023 7.1.0	**FINANCE** **Private Patient Service Debt Position** **ACTION: Seek update from Dave Osbourne and ask to attend next meeting to talk to the paper and to provide further detail of the work in the Working Group.**	**ACTION: Matthew Bunce**	**CLOSED** Dave Osbourne will attend July 2023 Audit Committee.	**MB**
04/2023 7.2.0	**FINANCE** **Losses and Special Payments Report** **ACTION: Claire Bowden to remove the £000 at the top of each column as this indicated that the values below were in thousands.**	**ACTION: Claire Bowden**	**CLOSED** **Update APRIL 2023:** The £000 was removed at the top of each column on Losses and Special Payments Report.	**CB**

Archwilio Cymru
Audit Wales

Velindre University NHS Trust – Detailed Audit Plan 2023

Audit year: 2022-23

Date issued: June 2023

Document reference: 3653A2023

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.

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About Audit Wales

Our aims and ambitions

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

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

I have now largely completed my planning work.

This Detailed Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice.

This Plan relates to our external audit of the Trust and so a separate Audit Plan will be issued in regard to our audit of the Trust's charitable funds.

It sets out the work my team intends undertaking to address the audit risks identified and other key areas of focus during 2023.

It also sets out my estimated audit fee, details of my audit team and key dates for delivering my audit team's activities and planned outputs.

Adrian Crompton
Auditor General for Wales

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 is set out later in this 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.

There have been no limitations imposed on me in planning the scope of this audit.

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.

The majority of my performance audit work is conducted using the International Organisation of Supreme Audit Institutions (INTOSAI) auditing standards. INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations

Financial statements materiality

My financial statements audit will concentrate on your risks and other areas of focus

My audit planning has identified the following risks:

Significant financial statement risk

- Management override

Other areas of audit focus

- IFRS16 – Leases
- Asset valuations
- Inventory
- Welsh Risk Pool

My performance audit will include:

- Structured Assessment – Core
- Structured Assessment – Deep dive review of investment in digital
- Local project – Follow-up of our quality governance review
- Local project – Examination of the setting of well-being objectives

Materiality

Materiality	£9.7 million
Reporting threshold	£487,000

Materiality £9.7 million

My aim is to identify and correct material misstatements, that is, those that might other cause the user of the accounts into being misled.

Materiality is calculated using:

- 2022-23 draft accounts gross expenditure of £973,161 million
- Materiality percentage of 1%

I report to those charged with governance any misstatements above a trivial level (set at 5% of materiality).

Areas of specific interest

There are some areas of the accounts that may be of more importance to the user of the accounts and we have set a lower materiality level for these:

- Remuneration report/senior pay disclosure – £1,000; and
- Related party disclosures – £10,000 for individuals' interests.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other ISAs. The ISAs require us to focus more attention on these significant risks.

Exhibit 1: significant financial statement risks

Significant risk	Our planned response
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 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.

Other areas of focus

I set out other identified risks of material misstatement which, whilst not determined to be significant risks as above, I would like to bring to your attention.

Exhibit 2: other areas of focus

Audit risk	Our planned response
IFRS16 – Leases A new accounting standard, IFRS16 Leases, has been adopted by the FReM for 2022-23. IFRS16 will significantly change how most leased assets are accounted for, as leased assets will need to be recognised as assets and liabilities in the Statement of Financial Position. There are also significant additional disclosure requirements specific to leased assets that will need to be reflected in the financial statements.	My audit team will: • consider the completeness of the lease portfolios identified by the health board/trust/authority needing to be included in IFRS16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and disclosed in accordance with the Manual for Accounts; and • ensure that all material disclosures have been made.
Asset Valuations The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office as a management expert; • test the appropriateness of asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Manual for Accounts; and • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.

Audit risk	Our planned response
Inventory Whilst decreasing, the inventory balance within the Trust's annual accounts remains material. In addition there have been material write-downs of some stock values during the financial year. There is a risk that these write-downs are not founded on correct assumptions, accurately calculated or complete.	We will undertake audit procedures to obtain assurance upon the accuracy and completeness of the write-downs undertaken during the financial year to help inform whether the inventory balance within the financial statements is materially correct.
Welsh Risk Pool The Trust hosts the Welsh Risk Pool Services on behalf of NHS Wales bodies in respect of costs associated settling clinical negligence claims, including structured settlement cases. As a result of the typically high value of these claims the aggregate value within the Trust's accounts far exceeds our materiality level. As a result, there is an inherent risk that any errors in presenting and disclosing these liabilities within the annual accounts could be material.	We will undertake audit testing and seek assurances from the work undertaken by other NHS Wales auditors in order to obtain assurance that the liabilities are materially correct.

Financial statements audit timetable

I set out below key dates for delivery of my accounts audit work and planned outputs.

Exhibit 3: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
2023 Outline Audit Plan	January – February 2023	February 2023
2023 Detailed Audit Plan	March – May 2023	June 2023
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements • Audit of Financial Statements Memorandum report	February – July 2023	July 2023 July 2023 September 2023

Planned performance audit work

I set out below details of my performance audit work and key dates for delivery of planned outputs.

Exhibit 4: key dates for delivery of planned outputs

Planned output	Work undertaken	Report finalised
Structured Assessment - core	Structured assessment will continue to form the basis of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. My 2023 structured assessment work will review the following core areas: • Board and committee cohesion and effectiveness; • corporate systems of assurance; • corporate planning arrangements; and • corporate financial planning and management arrangements. My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.	Fieldwork to commence between June and August 2023 with reporting by the end of October 2023.
Structured Assessment – deep dive review of investment in digital	In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Fieldwork to commence during the autumn of 2023 and reporting by April 2024.
Local project work – Follow-	My audit team will follow-up the Trust's progress in implementing actions to address the findings of my	Timing of fieldwork to be

Planned output	Work undertaken	Report finalised
up of quality governance review	2022 report on its quality governance arrangements.	confirmed, reporting by April 2024.
Local project work – Examination of the setting of well-being objectives	My audit team will assess the extent to which the Trust has acted in accordance with the sustainable development principle when setting/considering/renewing its well-being objectives.	Timing of fieldwork to be confirmed, reporting by April 2024.

Fee and audit team

In January 2023 I published the fee scheme for the 2023-24 year as approved by the Senedd Finance Committee. My fee rates for 2023-24 have increased by 4.8% for inflationary pressures. In addition, my financial audit fee has a further increase of 10.2% for 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 estimate your total audit fee will be **£243,111**.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without first discussing them with the Director of Finance.

Our financial audit fee is based on the following assumptions:

- The agreed audit deliverables sets out the expected working paper requirements to support the financial statements and includes timescales and responsibilities.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 5: breakdown of audit fee

Audit area	Proposed fee for 2023 (£)[1]	Actual fee for 2022 (£)
Audit of Financial Statements	**165,572**	**149,849**
Performance audit work:		
• Structured Assessment	64,974	61,817
• Local projects	12,565	12,118
Performance work total	**77,539**	**73,934**
Total fee	**243,111**	**223,783**

[1] The fees shown in this document are exclusive of VAT, which is not charged to you.

The main members of my team, together with their contact details, are summarised in **Exhibit 6**.

Exhibit 6: my local audit team

Name	Role	Contact details
Richard Harries	Engagement Director and Audit Director (Financial Audit)	richard.harries@audit.wales 02920 320640
Dave Thomas	Audit Director (Performance Audit)	dave.thomas@audit.wales 02920 320604
Steve Wyndham	Audit Manager (Financial Audit)	steve.wyndham@audit.wales 02920 320664
Darren Griffiths	Audit Manager (Performance Audit)	darren.griffiths@audit.wales 02920 32051
David Burridge	Audit Lead (Financial Audit)	david.burridge@audit.wales 02920 677839
Katrina Febry	Audit Lead (Performance Audit)	katrina.febry@audit.wales 07870 266701

I can confirm that my team members are all independent of the Trust and your officers.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We 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* and our Chair, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2022.

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

* QAD is the quality monitoring arm of ICAEW.

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 (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.

Through our Good Practice work we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.

Our newsletter provides you with regular updates on our public service audit work, good practice and events, which can be tailored to your preferences.

For more information about our Good Practice work click here.

Sign up to our newsletter here.

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Archwilio Cymru
Audit Wales

Audit Committee Update – Velindre University NHS Trust

Date issued: July 2023

Document reference: ACU202307

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

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

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

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

Contents

About this document

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

2 Also included is information on:

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

3 Details of future and past Good Practice Exchange (GPX) events are available on our website. Included as an appendix to this update is a programme of GPX events for 2023-24.

Accounts audit update

4 Our external audit of the Trust's 2022-23 financial statements is nearing completion and a separate paper has been issued to the Committee concerning this.

Performance audit update

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

Exhibit 1 – performance audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
2022 Audit Plan remaining work				
Local study - Operational Governance	To be confirmed	A review of each division's governance arrangements to support effective scrutiny of quality, performance, and finance.	**Not started** Timing of fieldwork to be confirmed, reporting by April 2024.	To be confirmed
2023 Audit Plan				

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment	Director of Corporate Governance and Chief of Staff	A review of the corporate arrangements in place at the Trust in relation to: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.	**In progress** Fieldwork to commence between July and September 2023 with reporting by the end of October 2023	To be confirmed
Structured Assessment Deep Dive - Digital	Executive Director of Strategic Transformation, Planning and Digital	Review of digital arrangements, with a focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	**Not started** Fieldwork to commence during the 2023 and reporting by April 2024.	To be confirmed
Local project work - Follow-up of	Executive Director of Nursing, AHP &	My audit team will follow-up the Trust's progress in implementing actions to address the findings	**Not started** Timing of fieldwork to be confirmed,	To be confirmed

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
quality governance review	Health Science	of my 2022 report on its quality governance arrangements.	reporting by April 2024.	
Local project work - Examination of the setting of well-being objectives	Executive Director of Strategic Transformation, Planning and Digital	My audit team will assess the extent to which the Trust has acted in accordance with the sustainable development principle when setting / considering / renewing its well-being objectives.	**Not started** Timing of fieldwork to be confirmed, reporting by April 2024.	To be confirmed

Other relevant publications

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

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

Title	Publication Date
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Digital inclusion in Wales	March 2023

Additional information

7 **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
Annual Report and Accounts 2022-2023	June 2023
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

8 There are no relevant Audit Wales consultations currently underway.

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Good Practice Exchange programme of events 2023-24

We will inspire and empower Welsh public services to improve.

We will do this by sharing knowledge, ideas and providing opportunities to talk to each other about the big issues facing public services in Wales.

Our programme of work will have a focus on prevention, sharing and exploring examples of approaches taken to prevent escalation of demand on public services. We will provide a safe space for you to share and learn from colleagues across Wales and beyond.

Date	Event	Location	Time	About the event
20 June 2023	**Together we can: Creating the conditions to empower our communities to thrive**	Online	10:00 – 12:00	In the last 15 years, local government in Wales has faced significant pressures, dealing with crisis after crisis, which has changed the way services are provided. Local authorities adapted well in responding to this challenge, devising and implementing a range of efficiency measures that reduced the cost of services, but also finding innovative ways of working. However, public services now face their most significant challenges in a generation. Wales already has some of the greatest and deepest levels of poverty in Great Britain and communities are facing a cost-of-living crisis. Coupled with a challenging financial outlook and an aging population, it's clear that public services will need to find

				different ways of maintaining services and continuing to support the wider community and in particular those most in need.
June 2023	**Unscheduled Care**	Video outputs to be published during June	-	During 2022, Audit Wales undertook a programme of work that assessed the extent to which the system and its leadership structures are responding to the pressures in the unscheduled system. Our work included an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow. We also reviewed progress being made in managing unscheduled care demand by helping patients access services which are the most appropriate for their unscheduled care needs.
20 July 2023	**Public services working in partnership**	Cardiff	09:00 – 13:00	Partnership working remains a priority for public services to deliver services against the increasing financial challenges. This event will look at how public bodies ensure value for money in these arrangements whilst providing high quality, meaningful, services to the public. Walking away from this event, delegates will be equipped with the tools and knowledge to help overcome the barriers to successful collaboration.
26 July 2023	**Public services working in partnership**	North Wales	09:00 – 13:00	
21 Sept 2023	**How to develop and implement your Digital Strategy**	Cardiff	09:00 – 13:00	The Covid pandemic has demonstrated the importance of digital in delivering modern services at pace. We have seen digital acting as a major catalyst in adapting to the

27 Sept 2023	**How to develop and implement your Digital Strategy**	North Wales	09:00 – 13:00	challenges we have faced. Public services need to continue with this agile and responsive mind set as the norm and not the exception. Working in partnership with Digital Communities Wales and Centre for Digital Public Services, this event will help equip public services with the practical tools and knowledge they need to successfully implement a Digital Strategy within their organisations.
11 Oct 2023	**How public services are managing increased costs of energy**	Online	10:00 – 12:00	The cost of living crisis is affecting many people across Wales. A new survey by Public Health Wales (Jan 23) has highlighted that people in Wales are increasingly worried about money, with 37 per cent agreeing that they are 'only just managing' and a further 11 per cent 'not managing' to make ends meet. This event will look at how public services are managing increased costs of energy and how this is affecting service delivery.
24 Oct 2023	**Housing and Homelessness**	Online	10:00 – 12:00	Homelessness services are under significant pressure. This is partly a result of the pandemic and the policy decisions taken by the Welsh and UK governments to suspend evictions from rented housing and to keep people living transitory lifestyles off the streets. The outcome of these decisions has however resulted in significant increases in demand. This event will share examples of approaches taken by organisations in Wales (and beyond) to meet the demand.

8 Nov 2023	**Financial Sustainability to include Medium Term Financial Planning**	Cardiff	09:00 – 13:00	Public services continue to face significant budget challenges. The need to respond to these pressures and the unprecedented speed with which the funding position and outlook has worsened, and the level of savings that may be required poses a significant risk to councils closing their medium-term funding gaps in a way which ensures value for money and appropriate application of the sustainable development principle. This event will provide practical advice and guidance to public services in managing these challenges going forward.
29 Nov 2023	**Financial Sustainability to include Medium Term Financial Planning**	North Wales	09:00 – 13:00	
5 Dec 2023	**Integrity in the public sector**	Online	10:00 – 12:00	Integrity is essential to public trust. 'Trust is built and maintained through competence, reliability, and honesty, as well as the building of genuine and sound relationships between the public sector and the public it serves. That means the public sector must be accountable for the management and delivery of public services and outcomes, for the direction and control of the work it does, the resources it manages, and for its behaviour and ethics.' [1] This event will look at how public services can promote a culture of integrity.

[1] Putting integrity at the core of how public organisations operate - https://oag.parliament.nz/good-practice/integrity/integrity-framework/preface.htm

23 Jan 2024	**Commissioning and Contract Management**	Online	10:00 – 12:00	As public services seek to close funding gaps in response to significant financial pressures the importance of commissioning and subsequent contract management in ensuring value for money and that the sustainable development principle is applied is likely to grow.
13 Feb 2024	**Key issues from Financial Accounts**	Cardiff	09:00 – 13:00	An opportunity to bring together Directors of Finance/ Society of Welsh Treasurers to network and share what they have learnt from the accounts audit process and provide useful insight to organisations present, in particular discussing challenges and successes.
21 Feb 2024	**Key issues from Financial Accounts**	North Wales	09:00 – 13:00	
19 March 2024	**Active Travel**	Online	10:00 – 12:00	The Active Travel (Wales) Act 2013 aims to make Wales a walking and cycling nation. Its purpose is to enable more people to undertake active travel for short journeys instead of using motorised vehicles where it is suitable for them to do so. This event will share examples of innovative approaches to active travel across Wales and beyond.

TBC	**Workforce Challenges**	Online	10:00 – 12:00	The challenge of recruiting staff to roles within the public sector is not new. But the added pressures of the COVID-19 pandemic and the cost-of-living crisis will continue to have a lasting impact on public services. As well as this, staff are becoming increasingly fatigued from responding to crisis after crisis. This event will showcase examples of innovative approaches to recruiting and retaining staff, as well as supporting staff through challenging times.

How our work fits with the wider audit programme

Tackling inequalities	Together we can: Creating the conditions to empower our communities to thrive A Wales of vibrant culture and thriving Welsh language Housing and Homelessness
Responding to the climate and nature emergency	Active Travel
Service Resilience and Access	Unscheduled Care Workforce challenges Public services working in partnership How to develop and implement your Digital Strategy How public services are managing increased costs of energy

Well managed public services	Financial Sustainability to include Medium Term Financial Planning Commissioning and Contract Management Integrity in the public sector Key issues from Financial Accounts

AUDIT COMMITTEE

ACHIEVING DECARBONISATION BY 2030: CALL TO ACTION

DATE OF MEETING	26/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Rhiannon Freshney, Trust Sustainability Manager
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	29/06/2023	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Climate change is one of the world's defining challenges and it requires immediate action from everyone. A landmark report by the United Nations in August 2021 said that human activity is changing our climate in unprecedented ways and that drastic reductions in carbon emissions are necessary.

1.2 A crucial way to mitigate the impacts of climate change is to reduce carbon emissions. In March 2021, following advice from the Climate Change Committee in December 2020, the Welsh Government set new targets for a 63% carbon reduction by 2030, an 89% reduction by 2040, and a 100% reduction by 2050. In addition, the Welsh Government set out a more challenging collective ambition for the Welsh public sector to achieve net zero carbon by 2030 (the 2030 collective ambition).

1.3 In June 2021, the Welsh Government published its Programme for Government 2021-2026 which puts tackling the climate and nature emergencies at the heart of the new government. The Programme for Government also makes a series of commitments to embed a response to climate change in everything the Welsh Government does.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Audit Wales have set out five calls for action for organisations to tackle the common barriers to decarbonisation in the public sector. These are:

- Strengthen your leadership and demonstrate your collective responsibility through effective collaboration
- Clarify your strategic direction and increase your pace of implementation Strengthen your leadership and demonstrate your collective
- Get to grips with the finances you need
- Know your skills gaps and increase your capacity
- Improve data quality and monitoring to support your decision making

2.2 Audit Wales are not making specific recommendations given the high-level nature of our review. However, they are encouraging public bodies – including the Trust - to consider the messages in their published report, and through their internal governance structures, set out publicly how they intend to respond to the calls for action.

2.3 The Trust has reviewed the five barriers and an assessment has been made against each call to action (Appendix 1).

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	Yes (Include further detail below)
	Compliance with the Well-being of Future Generations (Wales) Act and Environment (Wales) Act
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Investment in decarbonisation initiatives.

4. RECOMMENDATION

4.1 The Audit Committee are asked to **NOTE** the contents

Appendix 1

Calls for Action – Summary

1. **Strengthen your leadership and demonstrate your collective responsibility through effective collaboration**

Our Sustainability Strategy has created a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world-class services for our donors, patients and carers. The strategy has 10 themes, which were derived from the United Nations Sustainable Development Goals and the Well-Being of Future Generations Act and are designed to achieve our Trust Well-being Objectives. The suite of strategies, including the Trust This strategy is the start of a new phase of close engagement and collaborative working with others to share our resources and to work together do more with what we collectively have. This will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

2. **Clarify your strategic direction and increase your pace of implementation**

Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. The Trust has Our vision: become a sustainable organisations which contributes to a better world for future generations within our locality and across the globe. We have identified a number of key themes which we will focus on to deliver our ambitions to become sustainable organisation. In each theme we set out what we want to achieve, our objectives and the actions we will take. The strategy outlines what we want to achieve together with ten themes which we will focus on to deliver our ambitions;

- Theme 1: Creating Wider Value: Our Organisational Approach
- Theme 2: Sustainable Care Models
- Theme 3: Eliminating Carbon
- Theme 4: Sustainable Infrastructure
- Theme 5: Transition to a future of renewables
- Theme 6: Sustainable Use of Resources
- Theme 7: Connecting with Nature
- Theme 8: Greening our travel and transport
- Theme 9: Adapting to Climate Change
- Theme 10: Our people as agents of change

The Trust Well-being Objectives are currently under review. Following the approval of the Trust Strategy and Enabling Strategies, there is an opportunity to refresh the objectives to align with the Trust strategies. The approved suite of strategies will be the basis for the future objectives, and be the structure of the engagement process going forward.

Furthermore, the objectives refresh provides an opportunity to further address the recommendations made by Audit Wales in the Public Sector Readiness for Net Zero Carbon by 2030.

3. Get to grips with the finances you need

The Trust has created a prioritised Decarbonisation Action Plan that seeks to address our carbon footprint, which has projected costs for each project. Alongside this, the Trust has costed capital infrastructure projects including the new Velindre Cancer Centre, Radiotherapy Satellite Centre, and the Talbot Green Infrastructure Project. The new Velindre Cancer Centre is the Mutual Investment Model. The Trust still needs to explore understanding the investment into staff training, events and engagement.

4. Know your skills gaps and increase your capacity

Environmental Awareness training is a 'Mandatory' training, all staff are required to complete, and the Trust is over 80% compliant across all divisions. The training includes an overview of key legislation, including decarbonisation, biodiversity and tips on how to be more sustainable. However, we could do more; we have the opportunity to determining the appropriate skills across the Trust at varying levels. Through events, communications and engagement activities we are raising awareness and educating our staff, patients, donors and local community (notably Sustainable Jamboris). The Trust provides opportunities.

5. Improve data quality and monitoring to support your decision-making

We recognise that, inevitably, our day-to-day operations have an impact on the environment. The NHS is responsible for 2.6% of the total carbon footprint in Wales, and has fallen behind other sectors when it comes to response and reducing environmental impact. Across our estate, there are a number of key areas to tackle including energy consumption, single-use plastic, water usage, fuel and waste.

The consumption of resources is necessary for the provision of healthcare services and to provide a comfortable environment for patients, donors, staff and visitors. We also have a responsibility to be transition to a new, sustainable world that minimises the use of resources and creates wider value. The Trust has been working hard to increase our monitoring and management of data through our Performance Management Framework reporting, with regular updates of gas, electricity, water and waste with comparisons to our baseline figures of 2018/2019 and the previous year consumption. However, we can do more! Our major capital investments – Radiotherapy Satellite Centre, new Velindre Cancer Centre and Talbot Green Infrastructure Upgrade – all include enhance metering and monitoring of our consumption.

Call for Action – Detailed Overview

1. **Strengthen your leadership and demonstrate your collective responsibility through effective collaboration**

Proposed Questions	Response	Evidence	Areas for Development
Are we treating the climate crisis and the need to decarbonise as a real 'emergency'?	The Trust is developing progressive and ambitious plans to address and is treating the climate crisis as an emergency. Alongside our strategic ambitions, the Trust is undertaking large capital plans in the works (nVCC/TGI/RSC/IRS) which are seeking to address scopes 1,2 and 3.	• Trust Strategy – main objective • Sustainability Strategy	• Surveys twice a year to staff (senior and frontline) across the Trust to understand the culture / feeling towards the climate emergency
Can we demonstrate that decarbonisation is at the core of day-to-day business decisions and operations?	The Trust is working hard to embed decarbonisation throughout all business decisions and operations. This is embedded in our major capital schemes, however, we could progress this further with day-to-day operations. Within the Sustainability Strategy, we are seeking to embed a culture of sustainability through.	• Business Cases 15% waiting for sustainability • Service models – local care and travel last • Major capital schemes	
Is the urgency and scale of the challenge well communicated by senior leaders and understood throughout our organisation?	The Trust Strategy has sustainability as one of the five objectives of the organisation. There has been extensive engagement to communicate and highlight the		• Board briefing and education settings • Executive led Sustainability Management Board

	urgency and scale. There are regular board reports regarding sustainability and ongoing initiatives, performance management and events.		
Do we have specific and effective scrutiny and governance arrangements for managing the journey to net zero?	Yes – structured governance process in place.	• PMF reporting – monthly	• Standing agenda items on QSP, Trust Boards
Do we understand the main barriers to progress and how well are we collaborating to overcome them?	There are currently barriers for capacity for staff to continue to be engaged (through events of communications) or attend training. Furthermore, the Trust has ambitions to be an exemplar in the Well-being of Future Generations (Wales) Act 2015, and all facets that contribute to it, including decarbonisation. To deliver such an ambitious goal the Trust is not currently resourced to deliver all aspects of sustainability. Furthermore, consistent investment in training and development		• Development of shared action plan with key stakeholders

2. Clarify your strategic direction and increase your pace of implementation

Proposed Questions	Response	Evidence	For Further Consideration
Have we set out a clear strategic approach and action plan for decarbonisation? If not, why not?	Yes, the Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities.	• Sustainability Strategy • Trust Strategy • Decarbonisation Action Plan	• How we measure progress against actions
Have we given due consideration to recommendations from the Future Generations Commissioner on decarbonisation, including those within the Future Generations Report 2026?	Yes, cross referenced alongside the Well-being Goals & Trust Well-being Objectives		
Are we involving our staff, stakeholders and citizens in the development and delivery of our strategic approach?	Yes, the Trust Strategy and all enabling strategies, including the Sustainability Strategy was promoted through digital communications and through pop up events – including the Sustainable Jamboris. The strategies are integrated into the major capital projects, which seek to decarbonise.	• Participation is recorded for all events	
Have we collaborated with others to develop our overall approach?	Yes, the Trust collaborated with staff, HBs, Future Generations		• Targeted approach to collaboration and

	Commissioner Office, and through external engagement (via the Hefyd workstream).		communication to secure the biggest gains
How will our approach to decarbonisation help us deliver against other strategic objectives (including well-being objectives) as well as meeting the 2030 collective ambition?	The Trust has developed a detailed and ambitious Trust Strategy, with enably strategies including the Sustainability Strategy which has been cross referenced and integrated into the alongside the Well-being Goals & Trust Well-being Objectives. The Trust has developed Decarbonisation Action Plan (DAP) which outlines activities required to decarboinse our estate.	• Sustainability Strategy – Decarbonisation theme • New Velindre Cancer Centre • Talbot Green Infrastructure Upgrade • Radiotherapy Satellite Centre	
Do our other corporate strategies, policies and operations reflect the strategic approach we have set out for decarbonisation?	Policies, strategies and documentation are required to be assessed against through Equality Impact Assessment (EQIA) which includes each Well-being goal / Trust Well-being Objective. Within this, the policy author is required to outline how and where in the documentation it contributes to each Well-being Goal (notably for decarbonisation A Resilient Wales, A Prosperous Wales and A Globally Responsible Wales) and Trust Well-being Objective.	• EQIA form • Policy for policies	• Review exemplar organisations
Does our action plan set out clear milestones that align with the	Yes, Trust Strategy Sustainability Strategy, detailed DAP. The achieve	• Sustainability Strategy	

2030 collective ambition and is it being implemented at sufficient pace?	our goals, there are major capital projects; RadtioSC, nVCC, TGI	• Decarbonisation Action Plan	

3. Get to grips with the finances you need

Proposed Questions	Response	Evidence	Further Consideration
Do we know what we are currently spending on activities to help meet the 2030 collective ambition?	The Decarbonisation Action Plan (DAP) has projected figures incorporated within the documentation. The nVCC project has outlined/projected costs. The Talbot Green Infrastructure upgrade has projected costs and estimated carbon reduction. The RSC has incorporated reduced carbon and is fully costed. The IRS has incorporated reduced carbon and is fully costed. The large capital schemes will be ensure a significant reduction in carbon emissions across all of our organisation. However, the Trust seeks to educate and invoke behavioural change alongside this, and these have not been fully costed.	• Decarbonisation Action Plan • Reference Design – nVCC • FBC – nVCC • OBC – Talbot Green • FBC – RSC • FBC – IRS	• Understand costing for behavioural change interventions
Do we know how much we would need to spend to help achieve the 2030 collective ambition?	The Decarbonisation Action Plan (DAP) has projected figures incorporated within the documentation. The nVCC project has outlined/projected costs.	• Decarbonisation Action Plan • Reference Design – nVCC • Reference Design – nVCC	• Consideration to consider cost of sustainability as

	The Talbot Green Infrastructure upgrade has projected costs and estimated carbon reduction. The RSC has incorporated reduced carbon and is fully costed. The IRS has incorporated reduced carbon and is fully costed. The large capital schemes will be ensure a significant reduction in carbon emissions across all of our organisation. However, the Trust seeks to educate and invoke behavioural change alongside this, and these have not been fully costed. The Trust needs to consider all aspects of decarbonisation, including digital, people and waste to ensure the true cost of decarbonisation is considered.	• FBC – nVCC • OBC – Talbot Green • FBC – RSC • FBC – IRS	itemised cost within overall schemes
How are we deciding how much to spend on decarbonisation?	The large capital spend on nVCC, IRS, RSC Talbot Green Infrastructure Upgrade. There is limited with spend on current VCC site due to the major capital build. The Sustainability Strategy outlines themes and objectives which seek to decarbonisation, activities which achieve this aims will be prioritised.	• Decarbonisation Action Plan • Reference Design / FBC – nVCC • OBC – Talbot Green • FBC – RSC • FBC – IRS	
If we have not yet assessed the financial implications of the	Large portions of costs are integrated into the major capital programmes, and		• Itemise sustainable initiatives that form

2030 collective ambition, do we understand why we have been unable to?	have not been considered as separate line items.		part of the major capital schemesas line items so they may be recorded
What are we doing to collaborate with others, to understand the financial implications, and to share costs?	Throughout the Trust, there has been collaboration with other Health Boards and Welsh Government on all major capital schemes.	• Participation in national groups	• Actively record all instances of calobaration
Do our budgets and expenditure reflect the need to reduce carbon emissions urgently?	The Trust Strategy and project spend profile is aggressive and outlines the financial requirements to reduce carbon.	• Reflecting within major capital programmes	
Are we setting out a good level of detail in our financial statements in relation to decarbonisation spending?	The Trust had a DAP which captures expenditure which is supplemented by Business cases approved by Welsh Government detailing the specifics of each scheme.	• Major Schemes require completion of the recently introduced sustainability template	

4. Know your skills gaps and increase your capacity

Proposed Questions	Response	Evidence	Further Consideration
Do we know what skills are needed, both now and in the future, to ensure we can deliver against the 2030 collective ambition?	The Trust has made 'Environmental Awareness' as a core competency and the Trust has made it mandatory for all staff. The strategy outlines the requirement to enhance. Further development	• Sustainability Strategy • Mandatory training materials • Mandatory training compliance • Estates skills matrix	•

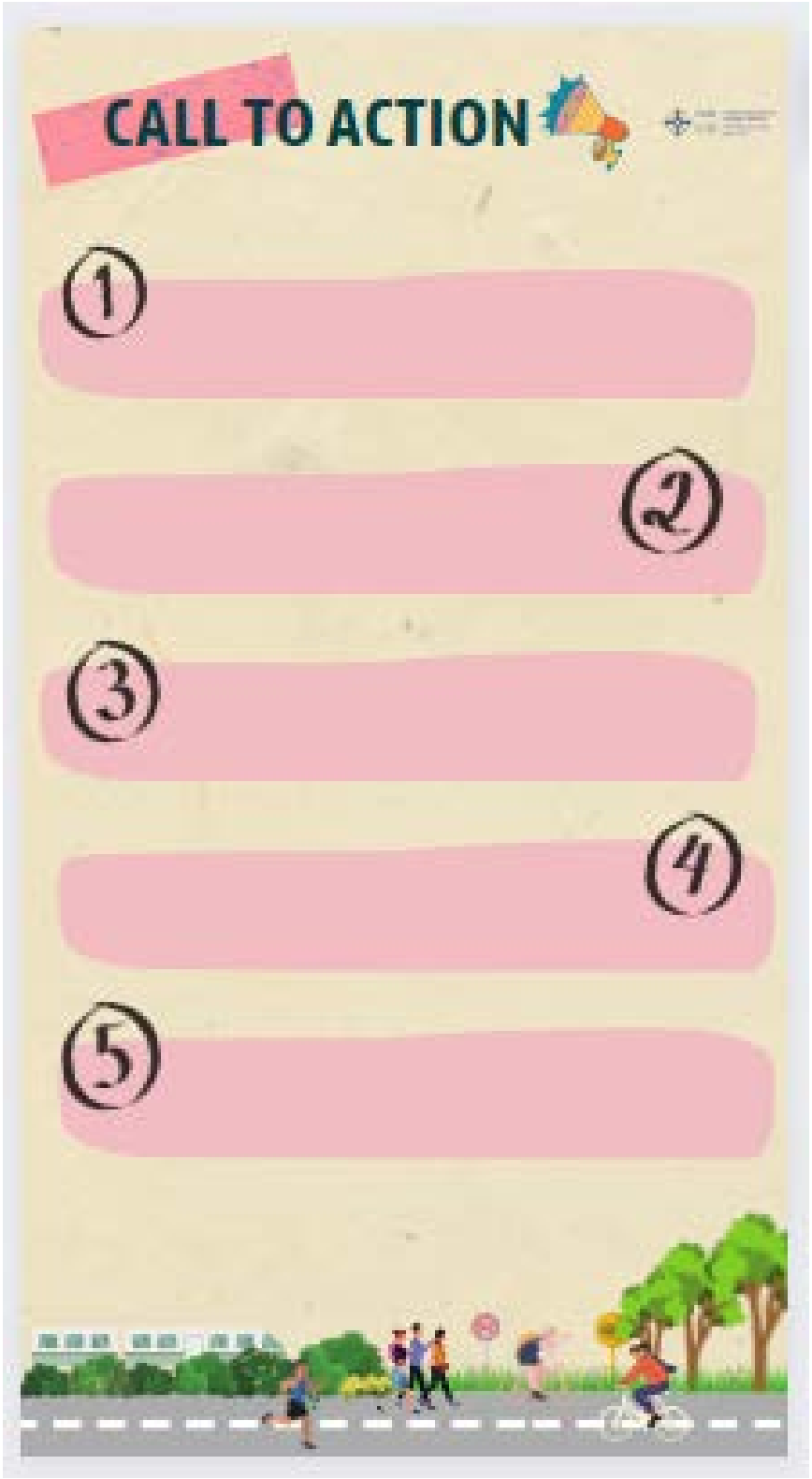
	is required in this area to understand what level of competency is required.		
Do we have a plan in place to deal with any identified skills and capacity gaps through training, recruitment or working with peers and stakeholders to share resources and expertise?	No	• Estates Team Compentancy matrix	

5. Improve data quality and monitoring to support your decision making

Proposed Questions	Response	Evidence	Further Consideration
Are we playing our part in building a system that will provide consistent, accurate, high-quality data on carbon emissions across the public sector to support transparency and scrutiny?	The Trust enhanced monitoring and management in the nVCC which will be a SMART hospital. The Trust is adopting a consistent and equitable approach for all projects across the various directorates, with TGI benefitting from enhanced metering and monitoring, The Trust submits required reports to Welsh Government, including the Net Zero Annual Report and Qualitative Reporting.	• Decarbonisation Action Plan • Reference Design / FBC – nVCC • OBC – Talbot Green • FBC – RSC • FBC – IRS • Estates Strategy • Net Zero Annual Report • PMF	• Development of a Green Tracker Trust wide to highlight live carbon consumption

Do we know what the existing data is telling us and what further data do we need to support decision-making?	The Trust is undertaking increased metering is required to determine hotspots for more targeted interventions. Whilst this is included in the nVCC / TGI / RSC would benefit on current sites.	• PMF •	• Meter Trending by building by area
Based on our understanding of our own data, do we have plans in place to take appropriate action?	Yes	• PMF	• Further development of building consumption and active monitoring of consumption
How can we improve our understanding of emissions resulting from our supply chain and relevant third parties?	The Trust captures the annual carbon emissions of procurement. However, the Trust notes the difficulty measuring the true impact of procurement. The Trust does not have capacity c cannot measure patient travel – limited understanding of Scope 3 emissions.	• Welsh Government Net Zero Reporting	

Draft Template for Internet/Comms



AUDIT COMMITTEE

ACCOUNTABILITY REPORT & ANNUAL ACCOUNTS 2022-23

DATE OF MEETING	26th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	• Emma Stephens, Head of Corporate Governance • Tracy Hughes, Head of Financial Operations • Sue Thomas, Deputy Director of OD & Workforce
PRESENTED BY	• Emma Stephens, Head of Corporate Governance • Chris Moreton, Deputy Director of Finance
APPROVED BY	• Lauren Fear, Director of Corporate Governance & Chief of Staff • Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes: • The Performance Report, which must include: o An overview o *Delivery and Performance analysis*

	• The Accountability Report, which must include:
	  o A Corporate Governance Report.
	  o A Remuneration and Staff Report.
	  o *Senedd Cymru/Welsh Parliament* Accountability and Audit Report.
	• The Financial Statements, including:
	  o The Audited Annual Accounts *2022-23*.
	
	The structure adopted in each of the reports is the one described in the Government Financial Reporting Manual 2022-23. NHS bodies may omit headings or sections where they consider that these are not relevant, however all of the content outlined in the manual must be included.
	
	The Accountability Report and Audited Annual Accounts 2022-23 will be presented to the Trust Board for **BOARD APPROVAL** on the **27th July 2022,** together with the Annual Performance Report, which was **ENDORSED FOR BOARD APPROVAL** by the Quality, Safety & Performance Committee on the 13th July 2022.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to: • **NOTE** the contents of the Accountability Report and Annual Accounts (***Appendix A & B***) for 2022-23, including the Letter of Representation (***Appendix Bi***) and Trust Response to Audit Wales regarding Trust Governance and Management Arrangements **(*Appendix Bii*).** • **ENDORSE for BOARD APPROVAL** the Accountability Report and Annual Accounts for 2022-23.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Board (*Board Development Session)*	(18/04/2023)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS In developing the Accountability Report this has also been discussed at various stages with Trust Officers, and presented at the April 2023 Trust Board Development Session, colleagues from NHS Wales Shared Services Internal Audit were also in attendance. It has also been shared with Audit Wales and Welsh Government with any feedback incorporated as appropriate. The Trust has also continued to receive regular updates on the Monthly Financial Reporting Position throughout the year, at each meeting of the Executive Management Board, Quality, Safety & Performance Committee and Trust Board, forming the basis of the Trust Accounts for the reporting period.	

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

APPENDICES	
Appendix 1	Letter of Representation 2022-2023
Appendix 2	Audit Wales Governance Statements Factsheets and Observations

1. SITUATION

The Accountability Report and Audited Annual Accounts 2022-23 is to be submitted by Audit Wales to the Finance Health and Social Service Group (HSSG), on the 31st July 2023, as a single unified PDF document, together with the Annual Performance Report.

The Trust Annual Report 2022-232 will be presented at the Trust's Annual General Meeting on the **29th September 2023**. A temporary change to the Trust Standing

Orders to allow the Trust to hold its **Annual General Meeting** for 2023 by the end of September are required due to the extended timeframe of Audit Wales audit programme of the Annual Accounts across NHS Wales.

The Accountability Report and Audited Annual Accounts 2022-23 is presented to the Trust Audit Committee to **ENDORSE FOR BOARD APPROVAL.**

2. BACKGROUND

For the 2023 reporting period the Trust Draft Accounts were submitted to HSSG Finance and Audit Wales on the 5th May 2023. The Trust Draft Annual Performance Report, Accountability Report (including the Governance Statement), and Draft Remuneration Report was also submitted to the HSSG Finance and Audit Wales on the 12th May 2023.

During the reporting period the Trust has continued to work in close collaboration with the Deputy Board Secretaries Group in partnership with Welsh Government to review the content, structure and reporting requirements of the Accountability Report. The purpose of which was to support a consistent approach across NHS Wales in regard of information and level of detail reported as appropriate.

3. ASSESSMENT

3.1 The purpose of the **Accountability Report**, which sits within the suite of Annual Report documents, is to report to the Senedd Cymru/ Welsh Parliament in respect of the Trust key accountability requirements. These have been reviewed in draft form at various stages by the Trust, Audit Wales and Welsh Government during April - July 2023. Any comments from these reviews have been incorporated as appropriate.

3.2 The Trust Governance Statement, which is contained within the Accountability Report, is supported by a separate Governance Statement from the Director of NHS Wales Shared Services Partnership and a Governance Compliance Statement signed by the Director of Health Technology Wales. These are not contained within the Annual Accountability Report, however, are available from the Director of Corporate Governance & Chief of Staff. These were also shared with the Trust Board for assurance at the April 2023 Trust Board Development Session.

3.3 Key aspects to highlight within the Governance Statement include:

- The revised reporting requirements following the introduction of the **Duty of Quality** and **Duty of Candour,** to reflect the provisions of the **Health and Social Care (Quality and Engagement) Act 2020** in conjunction with the updated Health and Care Quality Standards 2023. Reporting is overseen by the Trust Quality,

Safety & Performance Committee charged with providing advice and assurance to the Board in respect of the Trust's statutory requirements in this regard.

- The changes to the provisions with regard to a **Vice-Chair of Trusts** and changes to the **number of Board Members**, as per the **National Health Service Trusts (Membership and Procedure) (Amendment) (Wales) Regulations 2022**.

3.4 The Audited Annual Accounts outline the financial performance up to year end 31st March 2023.These have also been reviewed in draft form at various stages by the Trust, Audit Wales and Welsh Government during April - July 2023. Any comments from these reviews have been incorporated as appropriate.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Audit Committee is asked to:

NOTE the contents of the Accountability Report and Annual Accounts (***Appendix A & B***) for 2022-23, including the Letter of Representation (***Appendix Bi***) and Trust Response to Audit Wales regarding Trust Governance and Management Arrangements **(*Appendix Bii*).**

ENDORSE for BOARD APPROVAL the Accountability Report and Annual Accounts for 2022-23.

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	08 - Trust Financial Investment Risk 10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒ Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care. The Trust has a statutory requirement to ensure that proper arrangements are in place to secure economy, efficiency and effectiveness in the use of their resource.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required *There are no socio-economic impacts linked directly to the activity outlined in this report.*

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
	There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report.*
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is essential that the Trust complies with its statutory reporting requirements.

6. RISKS

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

	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust Accountability Report 2022-2023

CONTENT

VELINDRE UNIVERSITY NHS TRUST
SCOPE OF RESPONSIBILITY

Velindre University NHS Trust provides specialist services to the people of Wales. The operational delivery of services is managed through the Velindre Cancer Service and the Welsh Blood Service.

The Velindre Cancer Service delivers specialist cancer services for South East Wales using a hub and spoke model and provides a specialist treatment, teaching, research and development centre for non-surgical oncology. We treat patients with chemotherapy, Systemic Anti-Cancer Treatments (SACTs), radiotherapy and related treatments, together with caring for patients with specialist palliative care needs.

The Welsh Blood Service plays a fundamental role in the delivery of healthcare and covers the whole of Wales. It works to ensure that the donor's gift of blood is transformed into safe and effective blood components, which allow NHS Wales to improve the quality of life and save the lives of many thousands of people in Wales every year. We provide an antenatal screening service to several hospitals and offer all customer hospitals specialist laboratory services to assist in the investigation of complex serological problems. The Welsh Transplantation and Immunogenetics Laboratory, within the Welsh Blood Service, provides direct support to local providers of Renal and Stem Cell Transplant Services. It also operates a national panel of unrelated potential blood and stem cell donors – the Welsh Bone Marrow Donor Registry.

During the reporting period 2022-2023, Velindre University NHS Trust also hosted two organisations, which are outlined below:

NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

On 11 May 2012, the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 No.1261 (W.156) was laid before the National Assembly for Wales and came into force on 1 June 2012. The NWSSP is a dedicated organisation that supports the statutory bodies of NHS Wales through the provision of a comprehensive range of high quality, customer focused support functions and services.

NWSSP is hosted by Velindre University NHS Trust via a formal Hosting Agreement, signed by each statutory organisation in NHS Wales. The Director of NWSSP holds Accountable Officer status and holds a separate Accountability Statement with the Director General for Health in the Welsh Government. The Director of NWSSP produces and signs his own Governance Statement to support the Trust Chief Executive in signing the Velindre University NHS Trust Governance Statement.

HEALTH TECHNOLOGY WALES (HTW)

Velindre University NHS Trust received grant funding to continue the operation of Health Technology Wales. HTW is funded by Welsh Government under the Efficiency through Technology Programme. HTW was established to facilitate the timely adoption of clinically and cost effective health technologies in Wales, working with, but independently of, NHS Wales. Its remit covers all health technologies that are not medicines. This could be medical devices, surgical procedures, telemonitoring, psychological therapies, rehabilitation or any health intervention that is not a medicine.

HTW independently critically assesses the best available international evidence about the clinical and cost effectiveness of a health technology. This evidence is reviewed by experts and the HTW Appraisal Panel to put the evidence into the Welsh context. HTW also coordinates a Front Door process to support health technology developers to navigate NHS Wales. As well as its Front Door and appraisal functions, HTW also has roles in horizon scanning, evaluating uptake and disinvestment of technologies and providing advice to health technology developers. It does this in partnership with other organisations in NHS Wales to ensure there is no duplication of work and sharing of limited skilled assessment resources. The Director signs a Governance Compliance Statement to support the Trust Chief Executive in signing the Velindre University NHS Trust Governance Statement.

VELINDRE UNIVERSITY NHS TRUST SCOPE OF ACCOUNTABILITY

(*inc* HOSTED ORGANISATIONS)

Velindre University NHS Trust Board is accountable for Governance, Risk Management, and Internal Control for those services directly managed, and those managed via hosting arrangements. As Accountable Officer, the Chief Executive has responsibility for maintaining appropriate governance structures and procedures, as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which the Chief Executive is personally responsible. These are carried out in accordance with the responsibilities assigned by the Accounting Officer of NHS Wales. Directors of the Hosted Organisations are bound by a Governance Compliance Statement, (or their own Governance Statement in the case of NHS Wales Shared Services Partnership), with the Velindre University NHS Trust Chief Executive and in accordance with the individual hosting agreements with Velindre University NHS Trust.

Velindre University NHS Trust Annual Report outlines the different ways the organisation has continued to work both internally and with partners in planning and providing services as it moves beyond the recovery phase of the COVID-19 pandemic. It explains arrangements for ensuring standards of governance are maintained, risks are identified and assurance has been sought and provided. Where necessary additional information is provided in the sections of the Accountability Report, however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Velindre University NHS Trust wider Annual Report alongside this Accountability Report.

Throughout 2022-2023, Velindre University NHS Trust and NHS Wales has continued to adapt our governance framework to ensure we continue to operate in an open and transparent way, applying the learning derived from each stage of the COVID-19 pandemic. Further detail on how we maintained good governance arrangements during 2022-2023 are provided within the Governance Statement contained within this Accountability Report.

SCOPE OF THE ACCOUNTABILITY REPORT

In line with Welsh Government and HM Treasury Guidance, Velindre University NHS Trust has produced an Accountability Report for the financial reporting period 2022 - 2023.

The purpose of the Accountability Report, which sits within the suite of Velindre University NHS Trust Annual Report documents, is to report to the Welsh Government in respect of the key accountability requirements.

The Accountability Report will be signed and dated by the Velindre University NHS Trust's Accountable Officer - Chief Executive, and is made up of the following four sections:

I. Corporate Governance Report

II. Financial Accountability Report

III. Remuneration and Staff Report

IV. Parliamentary Accountability and Audit Report

CORPORATE GOVERNANCE REPORT

The purpose of the Corporate Governance Report is to explain the composition of Velindre University NHS Trust and its governance structures and how these support the achievement of the Trust's objectives.

The Corporate Governance Report includes the following sub sections:

- Director's Report
- The Statement of Accountable Officers' Responsibilities
- The Statement of Directors' Responsibilities in Respect of the Accounts
- The Governance Statement

DIRECTORS' REPORT

This Directors' report brings together information about the Velindre University NHS Trust Board including the Independent Members and Executive Directors, the composition of the Trust Board and other elements of its governance and risk management structure. It also includes the disclosures and reporting required by Velindre University NHS Trust relating to the day-to-day execution of the Trust's business.

Velindre University NHS Trust Board is made up of Executive Directors, who are employees of the Trust, and Independent Trust Board Members (IMs), who were appointed to the Trust Board by the Minister via an open and competitive public appointment process. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including: setting the organisation's strategic direction; establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour, and ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the Trust's performance across all areas of activity.

CHAIR & INDEPENDENT MEMBERS OF THE TRUST 2022-2023

Professor Donna Mead, OBE, Chair

Appointment:
Professor Mead was appointed Chair of Velindre University NHS Trust in May 2018.

Areas of Expertise:
Higher Education, Research, the NHS and Education, Partnerships and Collaboration.

Trust Board Committee Membership
Professor Mead Chairs the Trust Board, Remuneration Committee, Advisory Consultant Appointment Committee, Charitable Funds Committee, Academic Partnership Board and the Advancing Radiotherapy Committee. Professor Mead is also a member of the Quality, Safety & Performance Committee, Strategic Development Committee and Research, Development & Innovation Sub-Committee

Champion Role:
Trust Champion for Armed Forces and Veterans, University Trust.

Professor Mead is supported by six other Independent Members.

Mr. Stephen Harries, Vice Chair and Independent Member

Appointment:
Mr. Harries was appointed as an Independent Member of Velindre University NHS Trust in April 2017. In November 2018, Mr. Harries was appointed as Interim vice Chair of the Trust and was appointed on a permanent basis in April 2022.

Areas of Expertise:
Information Governance, Information Management and Technology.

Trust Board Committee Membership
Mr. Harries is Chair of the Strategic Development Committee and Transforming Cancer Services Programme Scrutiny Sub-Committee. He is also a member of the Remuneration Committee and the Quality, Safety & Performance Committee.

Champion Role:
Trust Champion for Digital and Mental Health.

Professor Andrew Westwell,
Independent Member

Appointment:
Professor Westwell was appointed as an Independent Member of Velindre University NHS Trust in August 2021.

Area of Expertise:
University Representative.

Trust Board Committee Membership
Professor Westwell is Chair of the Research, Development & Innovation Sub-Committee, and is also a member of the Strategic Development Committee, the Advancing Radiotherapy Fund Programme Board and the Academic Partnership Board.

Champion Role:
Trust Champion for Research, Development & Innovation.

Mrs. Vicky Morris, Independent Member

Appointment:
Mrs. Morris was appointed as an Independent Member of Velindre University NHS Trust in November 2021.

Area of Expertise:
Quality & Safety.

Trust Board Committee Membership
Mrs. Morris Chairs the Quality, Safety & Performance Committee and is a member of the Trust Audit Committee, NWSSP Audit Committee and the Trust Research, Development & Innovation Sub-Committee.

Champion Role:
Trust Champion for Infection Prevention, Vulnerability and Violence & Aggression.

Mrs. Hilary Jones, Independent Member

Appointment:
Mrs. Hilary Jones was appointed as an Independent Member of Velindre University NHS Trust in March 2020.

Area of Expertise:
Estates & Planning.

Trust Board Committee Membership
Mrs. Jones is a member of the Quality, Safety & Performance Committee, Charitable Funds Committee, Investment Performance Review Sub-Committee, Advancing Radiotherapy Fund Programme Board and Transforming Cancer Services Programme Scrutiny Sub-Committee.

Champion Role:
Trust Champion for Patient Engagement & Experience, Sustainable Development and Design.

Mr. Gareth Jones, Independent Member

Appointment:
Mr. Jones was appointed as an Independent Member of the Velindre University NHS Trust in December 2019.

Area of Expertise:
Legal.

Trust Board Committee Membership
Mr. Jones is a member of the Strategic Development Committee, Trust Audit Committee, Transforming Cancer Serves Programme Scrutiny Sub-Committee and the NWSSP Audit Committee.

Champion Role:
Trust Champion for Patient Information and Welsh Language.

Mr. Martin Veale, JP, Independent Member

Appointment:
Mr. Veale was appointed as an Independent Member of the Velindre University NHS Trust in April 2017.

Area of Expertise:
Finance, Audit & Governance.

Trust Board Committee Membership
Mr. Veale is Chair of the Trust Audit Committee, NWSSP Audit Committee and the Investment Performance Review Sub-Committee.
Mr. Veale is also a member of the Remuneration Committee and the Charitable Funds Committee.

Champion Role:
Trust Champion for Hosted Organisations and Performance Framework.

EXECUTIVE DIRECTORS (BOARD MEMBERS)

Mr. Steve Ham, Chief Executive Accountable Officer

Trust Board Committee Membership
Mr. Ham is a member of the Charitable Funds Committee and attends the Quality, Safety and Performance Committee, Strategic Development Committee, Local Partnership Forum, Remuneration Committee and Advisory Consultant Appointments Committee.

Dr. Jacinta Abraham, Executive Medical Director

Trust Board Committee Membership
Dr. Abraham attends the Quality, Safety and Performance Committee, Strategic Development Committee, Research, Development & Innovation Sub-Committee, Charitable Funds Committee and Advisory Consultant Appointments Committee.

Lead Function: Medical Director and Research

Mrs. Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

Trust Board Committee membership: Mrs. Williams is lead Executive for the Quality, Safety & Performance Committee and is a member of the Strategic Development Committee, Charitable Funds Committee and Research, Development & Innovation Sub-Committee and Transforming Cancer Services.

Lead Functions: Quality & Safety, Safeguarding, Infection Prevention & Control, professional lead for nursing, Allied Health Professionals and Healthcare Scientists.

Ms. Sarah Morley, Executive Director of Organisational Development & Workforce

Trust Board Committee Membership
Ms. Morley is Joint Chair of the Local Partnership Forum and attends the Strategic Development Committee, the Quality, Safety & Performance Committee and the Remuneration Committee.

Lead Function: Organisational Development & Workforce

Mr. Matthew Bunce, Executive Director of Finance

Trust Board Committee Membership
Mr. Bunce is a member of the Charitable Funds Committee and attends the Investment Performance Review Sub-Committee, Strategic Development Committee, Quality, Safety & Performance Committee, Audit Committee (Trust), Audit Committee (NWSSP) and the Local Partnership Forum.

Lead Function: Finance and Charitable Funds.

Mr. Carl James, Executive Director of Strategic Transformation, Planning, & Digital

Trust Board Committee Membership
Mr. James attends the Strategic Development Committee, Quality, Safety & Performance Committee and the Transforming Cancer Services Programme Scrutiny Sub-Committee.

Lead Function: Strategic Transformation, Planning, Digital & Estates.

EXECUTIVE TEAM MEMBERS (NON-BOARD MEMBERS)

Mrs. Lauren Fear,
Director of Corporate Governance & Chief of Staff

Principal advisor to the Trust Board and the organisation as a whole on all aspects of corporate governance and ensuring that the Trust meets the standards of good governance set for the NHS in Wales.

Mrs. Cath O'Brien, Chief Operating Officer

Responsible for oversight and ensuring effective arrangements are in place for Trust wide:

- Operational Service Delivery
- Service Improvement
- Catering
- Managing/Improving Divisional Performance
- IMTP Service Planning and Delivery
- Business Intelligence
- Business Continuity
- Emergency Planning
- Medical Devices

Mr. Alan Prosser, Director – Welsh Blood Service

Mr. Prosser is responsible for the operational management of the Service Division.

Mr. Paul Wilkins, Interim Director – Velindre Cancer Service

Mr. Wilkins is responsible for the operational management of the Service Division.

Further information in respect of the Trust Board, a Review of its Effectiveness, Committee Activity, the System of Internal Control and the Trust Assurance Framework are captured in the Governance Statement section of this report, which starts on page 26 and ***Appendix 1*** on page 63.

PUBLIC INTEREST DECLARATION

Each Velindre University NHS Trust Board Member has stated in writing that they have taken all the steps that they ought to have taken as a Director in order to make the Trust's auditors aware of any relevant audit information.

All Trust Board Members and Senior Managers within the Trust (including Directors of all Hosted Organisations) have declared any interests in companies, which may result in a conflict with their managerial responsibilities. No material interests have been declared during 2022-2023: a full register of interests for 2022-2023 is available upon request from the Director of Corporate Governance & Chief of Staff.

DISCLOSURE STATEMENTS

Information Governance:

The Trust operates an Information Governance (IG) Framework that ensures the Trust meets its Mandatory and Statutory obligations and other standards in relation to applicable legislation. Applicable legislation includes but is not exclusive to legislation which supports the principles of the European Convention on Human Rights, Human Rights Act 1998, Protection of Freedoms Act 2012, the Data Protection Act 2018 (includes the retained EU General Data Protection Regulations 679/2016 (UK GDPR)), Freedom of information Act 2000, Environmental Information Regulations 2004, Common Law Duty of Confidence and the Access to Health Records Act 1990.

This legislation is supported by non-legislative guidance such as: the Surveillance Camera Code of Practice 2021, Caldicott Principles and the Records Management Code of Practice for Health and Social Care 2022 which is in itself based on the Freedom of Information Act's Section 46 Information Management Code of Practice.

- **Information Governance Roles and Responsibilities:**

The Trust's Executive Director of Finance is the designated Senior Information Risk Owner (SIRO) who holds responsibility for information risk to the Trust Board. As an NHS Body, the Trust has in place a Caldicott Guardian, which is the Trust's Executive Medical Director. The two main divisions of the Trust also have a Caldicott Guardian in place. From a Digital perspective, the Trust's Chief Digital Officer links directly with the SIRO, Caldicott Guardians and Head of Information Governance (HoIG) at regular intervals throughout the year so that a rounded approach to Information Governance is undertaken. The lead for Information Governance for the Trust is the HoIG. From a Digital perspective, the Trust's Chief Digital

Officer links directly with the SIRO, Caldicott Guardians and HoIG at regular intervals throughout the year so that a rounded approach to Information Governance is undertaken.

The role of the HoIG is to ensure that there are effective controls and mechanisms in place to ensure that the Trust complies with its Mandatory and Statutory obligations as well as supporting staff ability via the delivery of Training and Awareness to comply with Information Governance fundamental principles and procedures.

- **Information Governance Overall Risk:**

Since the last Statement overall risk has reduced. This risk assessment is supported by the completion of an Internal Audit in Quarters 3 and 4 which provided “reasonable assurance” overall with assessments in the following four areas:

- Handling of sensitive information – Reasonable
- Information Governance training – Reasonable
- Recording of data breaches – Substantial
- Governance and oversight – Substantial

The overall reasonable assurance opinion reflected the fact that most of the areas identified for improvement by the audit were already covered by the Trust’s Information Governance Improvement Plan.

In relation to the handling of sensitive information, the SIRO and HoIG had identified in Financial Year (FY) 2021/22 that the lack of workable Information Asset Registers (IAR) meant that the handling of sensitive information was not as robust as it could be, and this has been identified within the work plan in the long term, this assessment was borne out by the audit. The Welsh Blood Service (WBS) has IAR’s in operation in 100% of its working areas. Velindre Cancer Centre (VCC) and the Corporate Divisions do not currently have working IAR’s in operation within their sphere of operation (0%). The IG Toolkit for 2022/23 and 2023/24 have both noted this as a requirement. In terms of the route to compliance, the Records Management Task and Finish Group (which was set up as a result of the Offsite Storage Incident) began to meet in Q1 2023/24. It has an overarching objective to instigate the operation and maintenance of IAR’s as Business as Usual (BAU) which will include periodical audits by the HoIG by the end of Q4 2023/24. The IG Toolkit Action Plan also notes that requirement to achieve compliance by the end of Q4 2023/24.

Face-to-face (either by teams or in person) Information Governance training is provided for all clinical staff joining the Trust, workshops are also provided where an incident has occurred to ensure that individuals and teams understand their obligations in relation to Information Governance. Reports are received monthly which enables the HoIG to target groups and individuals where compliance is low. SIRO and HoIG had identified in FY 2021/22 that all staff should receive identical induction training. This approach was supported by the audit, the audit

noted that Electronic Staff Record (ESR) compliance was lower than 75% in some areas at the time of the audit. The Trust has already taken steps to address the assessment of the audit, a recent check (end of May 23) has demonstrated that the area concerned has increased compliance from 65.38% in April 2023 to 72.55%, this has been achieved by a targeted training programme delivered by the HoIG. Further sessions are planned for July 2023 to further increase compliance rates. .

In addition to internal audit activity, the Trust utilises the Welsh Information Governance Toolkit (IG Toolkit) to measure its level of compliance against national IG standards and legislation. The toolkit is completed annually and provides evidence of areas of improvement achieved and identifies actions for the following year. The HoIG undertakes the annual completion of the toolkit to identify areas for improvement and provide background information. The priority areas for improvement have formed the basis of the IG work plan for 2022/23 and will continue to form its basis for 2023/24.

Evidence of Trust progress against the work plan is demonstrated within the quarterly Information Governance Report, which is presented for assurance to the Executive Management Board. The highlight report which is derived from the detailed report is presented for noting to the Quality, Safety and Performance Committee. The Independent Member of the Board whose portfolio includes Digital and Information Governance receives a copy of the full and highlight report, this enables them to seek additional assurance should it be required from SIRO and present that assurance to the Board. This process was assessed as providing substantial assurance to the Board in the IG Internal Audit of February 2023.

The Trust continues to process personal data using the “Privacy by Design” approach when procuring new systems and maintaining existing ones where personal data is processed. “Privacy by Design” enables the Trust to consider risk by using the Information Commission Office mandated Data Protection Impact Assessment process. The process helps analyse, identify and minimise the data protection risks of a system (both electronic and manual records). Article 35 of the UK GDPR states that Data Protection Impact Assessments (DPIA) are a legal requirement for processing data that is likely to result in high risk to the rights and freedoms of individuals. The Information Commissioner’s Office (ICO) advises that the completion of a Data protection Impact Assessment is good practice when processing personal data. A Data Protection Impact Assessment does not have to eradicate all risk but should help to minimise and determine whether the level of risk is acceptable in the circumstances.

In the period 1 April 2022 – 31 March 2023, 43 Data Protection Impact Assessments (DPIA) were approved with another 16 in progress. The DPIAs that remain in progress are related to ongoing long term projects.

The public have the right to request information held by the trust under the Subject Access Process in relation to the Freedom of Information Act 2000 (FOIA) and Environmental Information Regulations 2004 (EIR). In the period 1 April 2022 – 31 March 2023, the Trust received requests for information under the Freedom of Information Act per quarter as follows:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	43	23	53.49%
2	58	47	81.03%
3	36	23	63.89%
4	58	54	93.10%
Total for FY 22/23	195	147	75.38%

The Trust received requests for information under the Environmental Information Regulations per quarter as follows:

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	1	1	100%
2	2	2	100%
3	0	0	100%
4	0	0	100%
Total for FY 22/23	3	3	100%

In relation to FOI responses, the Trust undertook 1 Review requested by a member of the public. The Review was undertaken as a result of a multiple stranded complaint covering five specific areas, the areas and a summary of the Trust's response for each area are articulated:

There was a 92 working day delay in response

The Review found that the delay was due to the fact the information requested was not held at the time of the request. The review found that the delay could have been communicated with the requestor more effectively.

The document provided was undated and unsigned

The Review upheld the complaint regarding the date of the document and took the incident as a learning point. The Review did not uphold the complaint in this instance as unsigned documents were found to be entirely correct in relation to the Trust business concerned.

Each page within the document provided contained the faint lettering “draft”

The Review found that the original decision to share the information with the requestor was correct after the consideration of harm to the Public Interest.

The requestor asked for a copy of the final report, signed and dated

The Review found that the document had since been finalised and a copy was shared with the requestor as part of the Review.

An insight in to the 92 working day delay was requested

The Review found that the delay was sufficiently articulated within the Review process, the Trust apologised for the delay in the provision of the information to the requestor.

The Review was extended to take place within the 40 day timeframe where the review is complex, this was successfully achieved.

On 15th June 2022, the Trust received a notice from the ICO in relation to a complaint by a member of Staff under the Data Protection Act 2018. The Trust received the same complaint at the same time from the same individual. The complaint was related to the extension of a deadline in full response to a Subject Access Request made by the member of Staff. The extension was required because the request was complex and large in volume. The Trust wrote to the complainant on several occasions explaining the issues to them and the rationale for the extension of the timeline.

The member of Staff’s complaint was not upheld by the ICO, the finding from ICO on 22nd June 2022 as follows:

> “*In this case, you have demonstrated good practice of your data protection obligations and as long as you have resolved matters with* **redacted** *I see no further action for this case*”.

In relation to Subject Access Requests (SAR) made under the Data Protection Act 2018, the Trust received the following number of requests:

Medical Records

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	59	59	100%
2	34	34	100%
3	45	39	86.60%
4	45	45	100%
Total for FY 22/23	183	177	96.72%

Non-clinical

Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	2	2	100%
2	1	1	100%
3	0	0	100%
4	1	0	0%
Total for FY 22/23	4	3	75%

The SAR which has not yet been completed for Q4 2022/23 is deemed an unreasonable request due to the lack of clarity to define the data requested. Dialogue with the requestor is ongoing.

During 2022/23 the Trust reported 1 personal data breach incident to the ICO, this breach originated on 20th February 2022. The notification was submitted within the 72 hour breach reporting timeframe. The reported breach was a serious incident and further information is articulated within this Statement.

During 2022/23, the Trust has engaged appropriately with the ICO as part of its duty to conduct prior consultation for intended processing under Article 36 UK GDPR. The consultation has proven to be useful in identifying and mitigating risk where the intended processing may result in a high risk to the rights and freedoms of data subjects. The example in this case being consideration of best practice where the Trust may decide to act as a Processor to Consultants as a result of the liquidation of a private UK wide Cancer Treatment Centre.

The Trust has also engaged with the ICO informally to seek timely appropriate advice and guidance on operational issues, such as:

- Potential use of Body Worn Cameras and CCTV equipment in the new Velindre Hospital

and compliance with the Surveillance Camera Code of Practice 2021

- Use of social media platforms for fundraising purposes, especially assessing the consideration of Legitimate Interest as a lawful basis of processing
- The regulators position on the use of the Freedom of Information Act by companies seeking contract work in Public Bodies
- The regulators position on the frequency of requests by the same requestor made to the Trust under the Freedom of Information Act
- Monitoring of employees in the workplace and privacy considerations

Reported February 2022 – A Data Processor under contract to the Trust reported severe damage to a document storage site in which documentation was assessed by the Processor as completely destroyed. Reported to the Information Commissioners Office on 24th February 2022. The Information Commissioner undertook an investigation into the incident under Article 5(1)(f) UK GDPR which requires that the Trust as a Data Controller must ensure that personal data is;

"*processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures*"

The investigation focused on the Trust's activity in terms of the management of the contract with the supplier and whether the Trust acted appropriately.

The investigation concluded on 15th September 2022 and decided that regulatory action was not required in relation to the incident, this was because the risk of clinical harm to data subjects is low, that the Trust took steps to ensure that the site was appropriate for storing records by undertaking a procurement specification process. In this process the Trust set out specific requirements regarding the facility and the conditions in which the records would be stored.

In addition the All-Wales Terms and Conditions (revised May 18) were in place which sets out how information should be handled in accordance with data protection legislation.

The Information Commissioner welcomed the remedial steps taken by the Trust in light of the incident, in particular in that it has conducted work to examine patient records and establish what information is available electronically. In addition that the Trust has engaged the services of a specialist supplier who are storing damaged records to prevent further damage, destruction or loss. The Information Commissioner also noted that the Trust has engaged a replacement supplier and that a DPIA was carried out as well as a visit to ensure that the site meets the relevant requirements.

The Information Commissioner made clear recommendations, these being:

1. The Trust to consider the amount of information it currently holds, including information held in third party storage, and assess whether its retention remains necessary for the

intended purposes for processing. If this information is no longer required, take active steps to ensure that it is appropriately archived, or securely destroyed, and;

2. To ensure that, going forward, all third party storage contracts undergo a formal procurement process; including a site visit to ensure that the facility is appropriate and secure for the purposes of storage

In response to Recommendation 1, the Trust has been mandated, along with many other NHS bodies to retain patient data as a result of the ongoing UK Infected Blood Inquiry, but is putting together a case to destroy records of deceased patients, where those patients have been deceased for at least eight years, and where electronic records exist. This approach is in line with the NHS Wales Records Management Code of Practice for Health and Social Care 2022.

In response to Recommendation 2, the Trust ensures that all procurement where it involves the processing of personal data involves the Head of Information Governance and that where appropriate the necessary risk assessments are undertaken prior to the commencement of processing.

In addition to quarterly reporting to the Executive Management Board and Quality, Safety and Performance Committee, an Annual Information Governance Report is produced which provides an overview of the previous year's activity to the Board thereby providing assurance that the Trust continues to meet its Mandatory and Statutory responsibilities in relation to Information Governance.

Corporate Governance Code for Central Government Departments:

Whilst there is no requirement to comply with all elements of the Corporate Governance Code for Central Government Departments, Velindre University NHS Trust has undertaken an assessment against the main principles as they relate to an NHS public sector organisation in Wales. This assessment has been informed by the Trust's assessment of governance undertaken by the Trust Board in April 2023 (outlined on Page 50) and also evidenced by internal and external audits. The Trust Board is committed to the continuous review and pursuit of excellence in ensuring good governance. This includes the programme of work underway to review and strengthen the quality/detail of information provided to the Board for assurance. In addition, each of the Trust Board Committees conducts an Annual review of its Effectiveness, actively seeking further opportunities for continuous development and improvement ensuring good governance is maintained. To support good governance and strengthen assurance to the Board, the Chair has also established an Independent Members' Group which meets on a monthly basis, the purpose of which includes (but is not limited to) testing the robustness and effectiveness of the Governance and Assurance Framework.

The Trust is complying with the main principles of the Code where applicable, and follows the spirit of the Code to good effect and is conducting its business openly and in a transparent manner in line with the Code. The Trust Board recognises that not all reporting elements of the Code are outlined in this Governance Statement but are reported more fully in the Trust wider Annual Report. There have been no reported/identified departures from the Corporate

Governance Code during the year.

Sustainability:

Our Trust Strategy ‘Destination 2032’ outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. This is an exciting challenge for us which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity across the country. Our Sustainability Strategy has created a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patients and carers. The strategy has 10 themes, which were derived from the United Nations Sustainable Development Goals and the Well-Being of Future Generations Act and are designed to achieve our Trust Well-being Objectives.

The Trust recognises that its day-to-day operational activities have a direct impact upon the environment and is committed to meeting the legislative drivers set out by Welsh Government to address this when possible. Welsh Government have an ambition for the public sector to be carbon neutral by 2030. This ambition sits alongside the Environment (Wales) Act 2016 and Well-being of Future Generations (Wales) Act 2015 as legislative drivers for decarbonisation and embracing the Sustainable Development Principle within the public sector in Wales. The Trust will continue its work on carbon footprint monitoring in line with the NHS Wales Decarbonisation Strategy, to realise this ambition, the Trust has created tangible actions in a detailed Decarbonisation Action Plan. The Trust is taking ambitious action, both strategically through the Trust Sustainability Strategy and operationally to adapt to climate change and respond to climate risk through the development of new Velindre Cancer Centre Radiotherapy Satellite Centre and the Talbot Green Infrastructure upgrade project. Capital schemes are designed using projected climate data to ensure the design caters for global warming assessed within the lifetime of the build. This approach ensures as far as is reasonably practicable that fabric and systems used to control internal comfort remain fit for purpose. Alongside these major capital schemes, the Trust is actively educating our staff to instigate meaningful behavioral change, through events and raising awareness.

NHS Pension Scheme:

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

MINISTERIAL DIRECTIONS

A list of Ministerial Directions issued by the Welsh Government during 01 April 2022 - 31 March 2023 is available here. Whilst Ministerial Directions are received by Health Boards, these are not always applicable to Velindre University NHS Trust. The Trust has disseminated those of relevance to the Trust as appropriate during the reporting period and are detailed in ***Appendix 3*** on Page 76. In addition, Welsh Health Circulars issued by Welsh Government are logged by the Corporate Governance Function and assigned an Executive Lead(s) to assess the impact to the Trust and take forward any necessary actions as appropriate. A register and action log is maintained by the Corporate Governance Function. A list of Welsh Health Circulars issued by the Welsh Government during 01 April 2022 - 31 March 2023 considered of relevance to the Trust are also listed in ***Appendix 3*** on Page 76.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS ACCOUNTABLE OFFICER OF VELINDRE UNIVERSITY NHS TRUST

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer to the LHB/ NHS Trust/SHA. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

The Accountable Officer is required to confirm that, as far as he or she is aware, there is no relevant audit information of which the entity's auditors are unaware, and the Accountable Officer has taken all the steps that they ought to have taken to make themselves aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

The Accountable Officer is required to confirm that the annual report and accounts as a whole is fair, balanced and understandable and that they take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

The Accountable Officer is responsible for authorising the issue of the financial statements on the date they were certified by the Auditor General for Wales.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed by:

Mr. Steve Ham
Chief Executive

Dated: XX/XX/2023

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the LHB / NHS Trust and of the income and expenditure of the LHB /NHS Trust for that period.

In preparing those accounts, the directors are required to:

- make judgements and estimates which are responsible and prudent
- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The directors confirm that they have complied with the above requirements in preparing the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with the requirements outlined in the above mentioned direction by the Welsh Ministers.

By Order of the Board
Signed:

Professor Donna Mead
OBE Chair
Dated: XX/XX/2023

Mr. Steve Ham,
Chief Executive
Dated: XX/XX/2023

Mr. Matthew Bunce,
Executive Director of Finance
Dated: XX/XX/2023

GOVERNANCE STATEMENT

GOVERNANCE AND ACCOUNTABILITY FRAMEWORK

This Governance Statement details the arrangements in place for discharging the Chief Executive's responsibility to manage and control Velindre University NHS Trust's resources, and the organisations, which it hosts, during the financial year 2022-2023.

Due to the unique Accountable Officer status of the Managing Director of Shared Services Partnership (NWSSP), a Governance Statement for NWSSP has been requested and submitted by the Director of NWSSP to the Trust Chief Executive. This is available from the Director of Corporate Governance & Chief of Staff upon request and helps to inform this report.

The Director of Health Technology Wales (the Trust second hosted body), has also signed and submitted a *'Governance Compliance Statement',* detailing and declaring compliance with Velindre University NHS Trust governance arrangements. This has been submitted to the Velindre University NHS Trust's Chief Executive to provide assurance that Trust policy, systems and processes are being complied with to support good governance.

DISCHARGING RESPONSIBILITIES

The Trust Board has been constituted to comply with the National Health Service Wales, Velindre University NHS Trust (Establishment) Order 1993 No.2838 and subsequent Amendment Orders (1995 No. 2492, 1999 No.808, 1999 No 826, 2002 No.442 (W.57) and 2002 No.2199 (W.219 2009 No.2059, 2012 No.1261, 2012 No.1262, 2015 No.22, 2017 No.912, 2018 No.887). In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Trust Board members also fulfil a number of "champion" roles where they act as ambassadors for these matters (detailed on pages 8-11).

The Trust Board discharges its responsibilities through its Committees (listed in the table below) and scheme of delegation, which is set out in its Standing Orders.

There are nine Committees/Partnership Forums reporting directly to the Trust Board, which is supported by sub-Committees/groups in the discharge of functions outlined below:

Committee	Sub Committee
Academic Partnership Board	N/A
Advisory Consultant Appointments Committee	N/A
Audit Committee (Trust)	N/A
Audit Committee (For Shared Services to consider NHS Wales Shared Services Partnership) [NWSSP] Matters)	N/A
Charitable Funds Committee	Investment Performance Review Sub-Committee
Local Partnership Forum	N/A
Quality, Safety & Performance Committee	• Research, Development and Innovation Sub-Committee (for Research & Development activity) • Transforming Cancer Services Programme Scrutiny Sub-Committee (for programme delivery)
Remuneration Committee	N/A
Strategic Development Committee	• Research, Development and Innovation Sub-Committee (for Strategic / Innovation activity) • Transforming Cancer Services Programme Scrutiny Sub-Committee (for future direction setting)

At a local level, the Trust Board has agreed Standing Orders (SOs) for the regulation of proceedings and business.

The *Trust Standing Orders and Standing Financial Instructions* have been adopted from the Welsh Government's Model Standing Orders for NHS Trusts in Wales and are designed to translate the statutory requirements set out in the *National Health Service Trusts (Membership and Procedures) Regulations 1990 (1990/2024)* into day to day operating practice. Together with the adoption of a scheme of matters reserved to the Trust Board; a scheme of delegations to officers and others; and Standing Financial Instructions, the SOs provide the regulatory framework for the business conduct of the Trust and define its 'ways of working'.

These documents, together with the range of policies set by the Trust Board make up the Governance and Accountability Framework. The Standing Orders have been periodically updated to account for alterations in year; details in respect of the reviews are outlined on page 34.

The dates the Trust Board and Committees met during the period 2022-2023 are captured in ***Appendix 1*** on page 63.

Since the onset of the pandemic, the Trust has continually adapted and made changes to its governance arrangements to meet the challenges that were faced by COVID 19. The required response during each phase of the pandemic has meant that the whole organisation has had to work very differently both internally and with our staff, partners and stakeholders and it has been necessary to revise the way the Board governance and operational framework has been discharged.

It is acknowledged that in the unprecedented times that followed the onset of the COVID 19 pandemic, and each of its subsequent phases, there have been limitations on Boards and Committees being able to physically meet where this is not necessary and can be achieved by other means. In accordance with the Public Bodies (Admission to Meetings) Act 1960, the organisation is required to meet in public. As a result of the public health risk linked to the pandemic there have been limitations on public gatherings and has not therefore been possible to allow the public to attend meetings of our Board and Committees since the 24 March 2020. Whilst this is not in compliance with our Standing Orders with regards to allowing the public to attend meetings of our Board and Committees meetings, since that time, to ensure that the Trust's business has continued to be conducted in as open and transparent a manner as possible, the following actions have been taken and remain in place for the reporting period:

- The Trust is inviting all regular attendees to its Public Board and Committees via technological solutions.
- The meetings are closed session i.e. public are not invited to join the meetings in person. This has allowed the Trust to act in accordance with the social distancing guidelines that were introduced. From July 2020, the Trust has held its virtual Trust Board meeting in public. The public are able to observe the meeting from the widely

available video conferencing platform Zoom. A video recording of the meetings has also been made available on the Trust website. From March 2021, our Trust Board meetings have been held in person for Board members and members of the public continue to be able to observe the meeting via the video conferencing platform Zoom. Committee meetings have continued to be held virtually for the reporting period. It is planned to reinstate invitations to the public to join to its Public Board and Committees meetings in person where possible from April 2023-2024 onwards.

- Papers are published in advance of the Trust Board and Committee meetings and the minutes following their formal approval to be an accurate and true record at the subsequent meeting.

At the onset of the pandemic Velindre University NHS Trust established a dedicated incident Command and Control structure. The structure provided a formal escalation and de-escalation path to facilitate the Trust's planning and preparations for the emerging global COVID-19 pandemic and was consistent with the nationally recognised three tiered Command and Control structure. Effective arrangements were established as part of the Command and Control structure for ensuring that decision logs were maintained and reported appropriately. Whilst this structure was formally stood down due to the reduced COVID-19 transmissions, it was kept under review during 2022-2023 and was subsequently reinstated in response to the industrial action during quarter 3 and quarter 4. The frequency of GOLD COMMAND meetings during this period has been continually assessed and flexed in line with the needs of the industrial action, and its interface with the Welsh Blood Service and Velindre Cancer Service SILVER COMMANDs.

COMMITTEE ACTIVITY

In line with the Trust's Standing Orders, each Committee formally reports annually to the Trust Board on its work during the year detailing the business, activities, attendance and main issues dealt with by the Committee in the reporting year. Copies of the Committee Annual Reports for 2022-2023, which outline the activity of each of the Committees for the year ending 31 March 2023, are available on the Trust Internet site here. In addition, each Trust Board meeting receives a highlight report outlining the issues and activity considered and addressed by each Committee at its last meeting. The Trust has a process where Committees schedule a pause at the end of each meeting to discuss the key issues they want to raise with the Trust Board through the highlight report process under the following headings:

ALERT / ESCALATE
ADVISE
ASSURE
INFORM
APPENDICES (*as required*)

Each Committee Highlight Report is presented to the Trust Board by the Committee Chair. Similarly, each Committee Highlight Report is available within the Trust Board papers on the Trust's Internet site here. A further enhancement to the governance framework has been the embedding of the monthly meeting of the Independent Members Group which provides an opportunity for each of the Committee Chairs together with the Trust Chair, Chief Executive and Director of Corporate Governance & Chief of Staff, to discuss the triangulation of information across the Committee structure and the wider Trust.

The Terms of Reference for each Committee are reviewed annually in line with the Trust's Standing Orders, or more frequently if deemed necessary by the Committee or Trust Board. The Terms of Reference for all Committees are available on the Trust's Internet site here.

Key highlights and issues considered by the Trust Board and its Committees during 2022-2023 are included in ***Appendix 1*** of the Governance Statement on **page 63.**

Minutes and papers of all Public Trust Board and Committee meetings are also published on the Trust Internet site here.

During 2022-2023, key aspects of Trust Board business and issues delegated to the Audit Committee for consideration and advice, including action taken, included but were not limited to the following:

- Agreement of the Internal and External Audit Plans for the year.
- Receiving Internal and External Audit Reports and subsequently monitoring progress against Audit Action Plans. The Audit Action Plan, which tracks the implementation of the recommendations of Audits is regularly reviewed by the Audit Committee. A review of the existing monitoring and tracking arrangements has been undertaken at the beginning of 2022-2023 to strengthen this process in partnership with Internal Audit.
- Agreeing the Annual Counter Fraud Plan and monitoring counter fraud activities.
- Review of the Declaration of Interests and Gifts, Hospitality, Sponsorship and Honoraria Register.
- Monitoring the development of the Trust's Accountability Report.
- Monitoring of Governance Arrangements across the organisation, including hosted bodies.
- Monitoring overall risk management process by reviewing the Trust Risk Register at each meeting.

Further details in respect of the activity of the Audit Committee during 2022 - 2023 is captured in full on the Trust website here.

BOARD ASSURANCE FRAMEWORK

To provide a holistic overview and avoid duplication, please refer to the **Risk Section** on Page 40 of this **Governance Statement** where the **Board Assurance Framework** is fully detailed in the context of the wider Trust Risk Management Framework.

ENGAGEMENT WITH THE LOCAL PARTNERSHIP FORUM

In support of the Trust Board, the Trust also has a Local Partnership Forum that met five times during 2022-2023, with Joint Chairs who are each nominated from the Trade Union representatives and Executive Directors. The role of the Local Partnership Forum is to supply the main (but not only) forum within the Trust where the Directors of the Trust and Trade Union Representatives can discuss together and develop appropriate directions and responses to all major service development and change management issues.

Examples of engagement with the Local Partnership Forum during 2022-2023 are outlined in ***Appendix 1*** on page 63.

TRUST BOARD DEVELOPMENT AND EFFECTIVENESS

During 2022-2023 the Trust Board has received six Board Development sessions covering a number of key areas including the following:

April 2022

- Velindre Cancer Service Show and Tell
- Arts, Health and Wellbeing
- Annual Integrated Board Effectiveness Assessment
- Health and Social Care (Quality and Engagement) (Wales) Act 2020 – Preparedness Update
- Radiation Services Presentation
- VCC Patient Engagement Strategy Update: Journey So Far

June 2022

- Organisational Design
- Working Together - NHS Wales Shared Services Partnership (NWSSP) and the Trust
- Internal Audit and Audit Wales Reflections
- Board Writing, Processes and Templates
- Style and Approach – Seven Step Approach to Evaluating Assurance

- Performance Management Framework Update
- Risk Management Framework Training
- New Velindre Cancer Centre (nVCC) Approach to Bidder Selection

October 2022

- PREVENT/Contest Training
- Infection Prevention and Control Showcase and lunch with the Board
- Performance Management Framework
- Equality, Diversity & Inclusion (ED&I) Session – Focus on Race

November 2022

- Refresh of Board Risk Appetite
- Refresh of the Trust Assurance Framework Strategic Risks

December 2022

- nVCC Full Business Case
- Value Based Healthcare
- Finance Contracting and Commissioning Showcase
- Duty of Candour and Quality
- Recruitment Journey – Roles and Responsibilities
- Building our Future Together

February 2023

- Compassionate Leadership
- Intellectual Property Workshop
- nVCC Discussion
- IMTP and Accountable Officer Letter

In addition to the Board Development arrangements outlined above, the Trust Board has continued to receive an externally facilitated Board Development Programme designed to support the Board and Executive Team in meeting the challenges it is facing in the continually evolving environment within which it is operating. The Programme is made up of a number of parts and has covered (*although not limited*) to the following key areas of development:

- Building a high performing leadership team.
- Strategic decision-making capabilities and prioritisation.
- Building organisational capacity and capability including developing a highly effective and business-focused cadre of senior managers.
- Challenging areas of conflicting styles and behaviour.
- Developing clear strategies for harnessing individual differences to enable the Executive Team to work as a cohesive whole.

- Better understanding organisational dynamics in order to improve matrix working and embed change management capability across a diverse and dispersed organisation.

Executive and Independent Member visits ('15 Step Challenge process') with our staff have also recommenced as COVID-19 restrictions have eased to gain greater insight to the multi-faceted work undertaken by our staff across the Trust, and also better understand the different pressures faced on a daily basis. The Trust was due to commence piloting utilisation of the '15 Step Challenge process' in March 2020, however, the pilot was initially paused due to the pandemic.

The process that has been developed is based on the NHS England 15 Step Challenge process designed in 2017 for outpatient and clinic settings and is intended to be used as a framework using Plan, Do, Study, Act (PDSA) improvement methodology within the Welsh Blood Service and Velindre Cancer Service.

STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

The Trust approved a revised set of Standing Orders and Standing Financial Instructions for the regulation of proceedings and business to ensure the following issues were addressed:

- **January 2023 –** Amendments to Trust Standing Orders Schedule 3.0, resulting from the Annual review of the Terms of Reference and Operating Arrangements in respect of the Quality, Safety & Performance Committee.
- **February 2023 –** Amendment to the Trust Standing Orders (via Chairs Urgent Action) the revised membership of the Trust Board in line with The Health and Social Care (Quality and Engagement) (Wales) Act to comprise of one additional Executive Director.

TRUST BOARD APPOINTMENTS DURING 2022-2023

The Trust made the following Trust Board appointments/reappointments during 2022-2023:

Independent Members

- Mr. Stephen Harries was appointed as an Independent Member of Velindre University NHS Trust in April 2017. In November 2018, Mr. Harries was appointed as Interim vice Chair of the Trust and was appointed on a permanent basis in April 2022.

Executive Team Members

- In February 2023, the portfolio for the Director of Strategic Transformation, Planning & Digital was revised to be that of an Executive Director, following the revised membership of the Trust Board in line with The Health and Social Care (Quality and Engagement) (Wales) Act, to comprise of the Vice Chair and one additional Executive Director.

There were no vacancies in the Trust Board membership during 2022-2023, as such there was no adverse impact on the balance of the Board and decision making during the reporting period.

Further details on the Trust Board appointments are provided in the Trust Remuneration Report on **page 84.**

PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

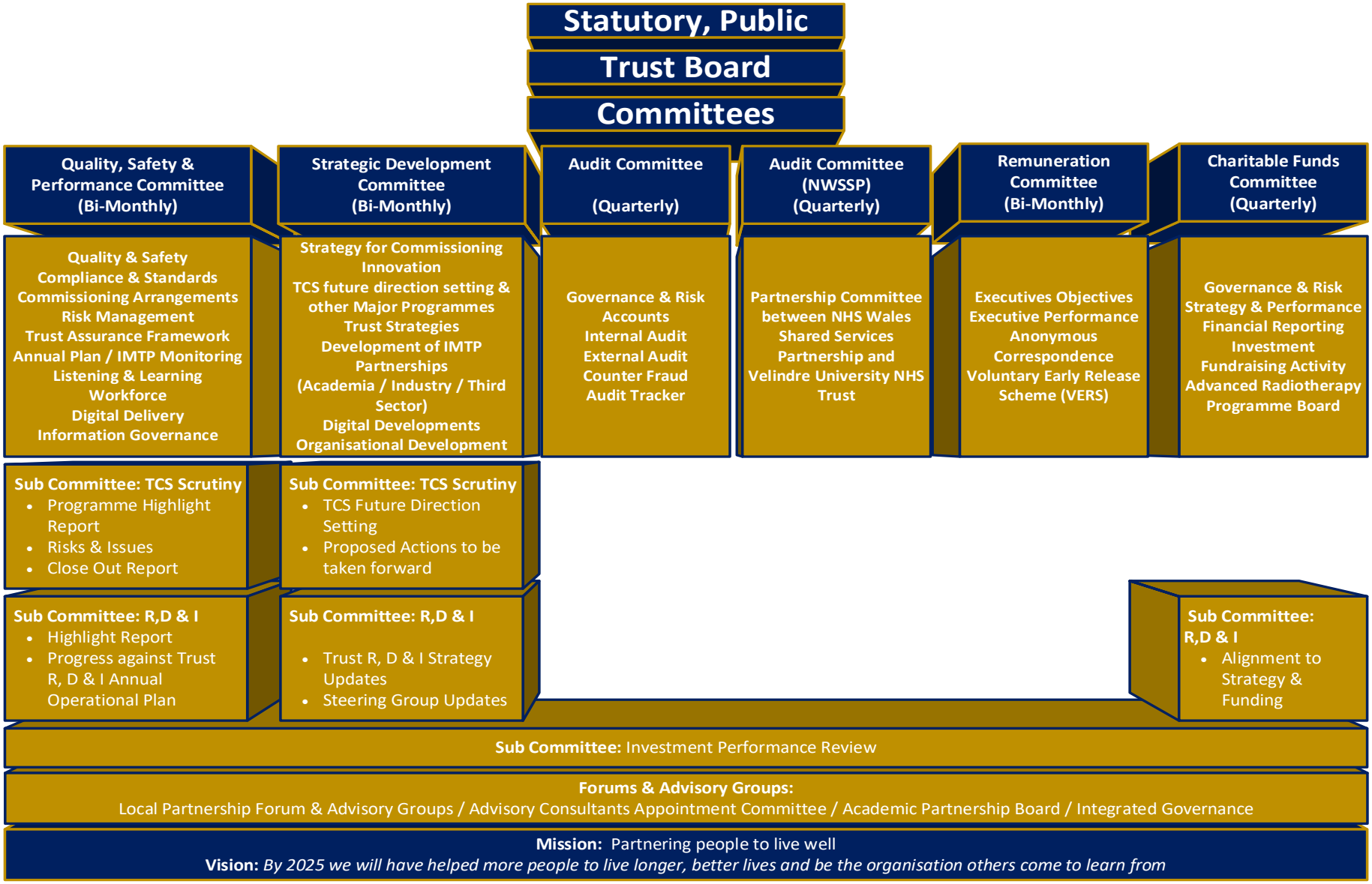
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks, it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2023, and up to the date of approval of the 2022-2023 Annual Report and Accounts.

The Welsh Government requires that the Trust operates within the wider governance framework set for the NHS in Wales and incorporating the standards of good governance set for the NHS in Wales (as defined within the Citizen Centred Governance principles and Standards for Health Services in Wales), together with its planning and performance management frameworks.

An overarching summary of the Trust's Governance and Accountability Framework is illustrated overleaf:

Trust's Governance and Accountability Framework



GOVERNANCE OF THE CHARITABLE FUNDS

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 the Trust Board serves as its agent in the administration of the Charitable Funds held by the Trust.

As part of their induction programme, new Executive Directors and Independent Members of the Trust are made aware of their responsibilities as Board Members of Velindre University NHS Trust and as Corporate Trustees of Velindre University NHS Trust Charity.

The Trust Board as Corporate Trustee is ultimately accountable for Charitable Funds given to Velindre University NHS Trust Charity. In order to facilitate the administration and management of these funds the Trust Board has established a Charitable Funds Committee (CFC) to provide advice and recommendations to the Board. Committee meetings are held every three months and otherwise as the Committee Chair deems necessary. At least two members must be present to ensure the quorum of the Committee.

The CFC is supported by the Charitable Funds Senior Leadership Group that meets on a monthly basis.

The CFC is also supported by an Investment Performance Review - Sub Committee, to oversee the investments made by the Charity.

Further information in respect of the Charitable Funds is available in the Trustee's Annual Report which can be found on the Trust website here.

HOSTED ORGANISATIONS SYSTEMS OF INTERNAL CONTROL AND ASSURANCE

Hosted organisations utilise the existing Trust Committee Structure (Accountability & Governance Framework) illustrated on page 36 of this Governance Statement.

A separate Velindre University NHS Trust Audit Committee is held to consider issues relating specifically to NWSSP, having the same Chair and Independent Membership as the Velindre University NHS Trust Audit Committee. Information relating to the governance arrangements in NWSSP is contained within the Director's Governance Statement to the Velindre University NHS Trust Chief Executive which is available from the Director of Corporate Governance and Chief of Staff upon request.

NWSSP has an 'NHS Wales Shared Services Partnership Committee' which was established as a sub-committee of Velindre University NHS Trust Board in 2012 to comply with Ministerial Directions. The NWSSP Committee has membership from each statutory body in NHS Wales, and is chaired by an Independent Chair. The NWSSP Committee reports to Velindre University NHS Trust Board and all other health body Boards in Wales via their representative member on the Committee. NWSSP have their own Standing Orders which are appended to the Velindre University NHS Trust Standing Orders.

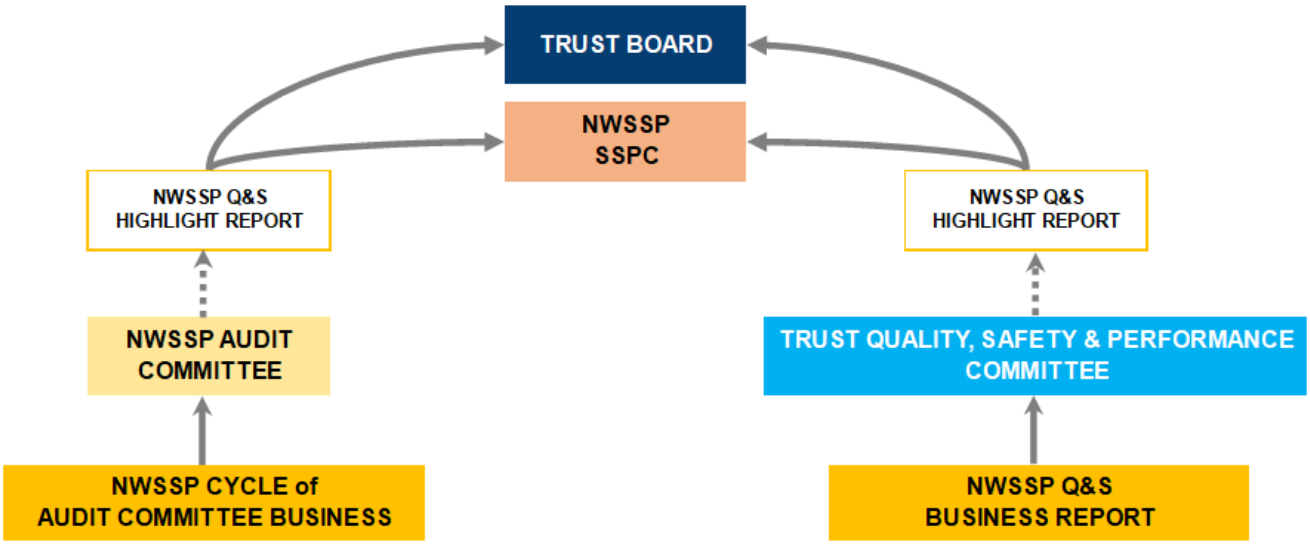
Currently, organisations hosted by Velindre University NHS Trust are able to link with Trust Board Committees and Management Groups where appropriate to ensure assurance is provided for the governance arrangements, including statutory compliance for the areas remaining within the Trust's area of responsibility.

In May 2021, a review was undertaken by Velindre University NHS Trust in partnership with NWSSP to consider arrangements for Quality & Safety governance in respect of the Shared Services Partnership Committee. This included consideration of the culture and approach adopted by the Velindre Board following the creation of the Quality, Safety & Performance Committee in November 2020. In addition, it also considered the approaches with other hosted organisations to support in considering different models and what may work best to fulfill the purpose agreed by the Shared Services Partnership Committee – to "advise and assure the Shared Services Partnership Committee and Accountable Officer on whether effective arrangements are in place for quality and safety" (in line with the approved NWSSP Standing Orders). This was coupled with ensuring that Velindre University NHS Trust Board, as the host organisation and statutory body, also having

appropriate assurance to fulfill its accountabilities in this respect. The review recommended that an additional section be added to the start of each Trust Quality, Safety & Performance Committee to cover NWSSP Quality and Safety business. This approach was considered sufficient for the volume of business at this time, and in quarter 4 of FY 2022-23 has been subject to further review as the NWSSP business model continues to develop. This has been reflected in the Trust Quality, Safety & Performance Committee Cycle of Business, and reported in the March 2023 meeting of the Committee.

In line with the arrangements for the Velindre Audit Committee for Shared Services, a separate highlight report is produced for this section of the Committee and this is shared with the Shared Services Partnership Committee and the Trust Board to provide assurance. A summary overview of these arrangements is provided below:

Quality & Safety (Q&S) Governance Arrangements for
NHS Wales Shared Services Partnership Committee (SSPC)



A review of the existing governance reporting arrangements in place for Health Technology Wales has also been taken forward in quarter 4 of FY 2022-23 for development and implementation during the 2023-2024 reporting period onwards. This will be subject to further ongoing continuous review as the governance assurance reporting arrangements continues to develop and mature and ensure its effectiveness.

CAPACITY TO HANDLE RISK

The organisations hosted by Velindre University NHS Trust maintain and manage their own risk registers and comply with the Trust escalation processes to ensure the Trust Board is made aware of any significant relevant risks relating to the Trust Board's responsibilities via the Trust Risk Register as necessary.

Risks relating to hosted organisations will only be escalated to the Velindre University NHS Trust risk register where matters directly affecting the Trust are apparent. Matters relating to service delivery and performance are a matter for hosted bodies to receive, manage, and escalate as necessary to the relevant sponsor body.

Information on the risks managed and mitigated during 2022-2023 is detailed in the Trust Risk Register which is received by the Trust Board. Trust Board papers are available on the Trust Internet site here.

RISK MANAGEMENT

The Trust has an approved Risk and Assurance Framework and associated policies in place. The policies detail a robust risk assessment process to identify, assess and manage organisational risks, which are reported on a risk register to the Trust Board, in line with risk appetite levels set by the Trust Board. The underlying risk principles applied throughout this framework are consistent with the overarching principles of HM Treasury's Orange Book *'Management of Risk – Principles and Concepts', 2020; and ISO 31000: 2018 'Risk Management – Guidelines'*. The framework also supports the UK Corporate Governance Code 2018 and the Financial Reporting Council's '*Guidance on Risk Management, Internal Control and Related Financial and Business Reporting'*.

The overarching Trust Risk Management Policy, approved by the Trust Board in September 2022 provides an overarching and strategic level document for the framework of managing risk in Velindre University NHS Trust:

"The primary objective of the Policy is to support staff across the Trust to identify and manage the risks that may prevent the achievement of the Trust's objectives. This includes assessing risks to patient and donor safety, compliance across our legal and regulatory frameworks and risks attached to our key dependencies, core processes, and stakeholder expectations and in so doing, the achievement of Trust Strategy. It is also important to emphasise that the Trust's commitment to quality and safety is

the 'golden thread' throughout the organisation and recognise the key role that a strong risk management culture has in that. As with everything the Trust does, this is achieved by putting our patients and donors at the centre of everything we do, working towards optimum quality, safety and experience and continual learning and improving.

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

Alongside the Risk Management Policy, there is a Trust Risk Management Procedure, which:

"… supports the application of the Risk Management Policy across the Trust. It provides details on how staff across the Trust should apply the risk management process across the Trust to identify and manage the risks which prevent the achievement of the Trust's strategic goals and objectives. It is not designed to be a standalone document, and must be read in conjunction with the Risk Management Policy, which describes the context of why risk management is important and how the Risk Management Framework operates across the Trust."

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

The Quality, Safety & Performance Committee has a remit to review risks, however, during 2022-23 the committee's focus has been more so on ensuring that the information in the risk register is accurate and providing the appropriate details to enable effective assurance. During 2023-24 the committee's focus will be on scrutinising risks in the register. The committee provides: assurance to the Trust Board that the risk register appropriately reflects the most significant risks facing the organisation, through a Quality and Safety lens; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

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

Executive Management Board Directors support and promote risk management. They ensure that risk management is integrated into all activities, and demonstrate leadership and commitment by ensuring:

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

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

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

In summary, the Trust's risk management framework:

- promotes consistency and transparency by articulating an overarching framework for managing risk and establishing a common risk language across Trust;
- explains how the three lines of defence operates;
- explains how risk management is aligned to the governance structures across the organisation;
- defines risk management roles and responsibilities for individuals and teams within VUNHST;
- ensures that risk management processes support and align with the overarching strategy for the Trust, in which the golden thread is our commitment to quality and safety, ensuring that

we put our patients and donors at the centre of everything we do;

- recognises that timely and accurate monitoring, review, communication and reporting of risk are critical to providing:

    - early warning mechanisms for the effective management of risk occurrences
    - assurance to our patients and donors
    - assurance through governance structures to the Trust Board and to our partners/stakeholders such as Regulators and Inspection bodies
    - a sound platform for organisational resilience
    - supports decision-making through risk based information;
    - and supports the continued development a culture where proactive risk management is integrated into all Trust business.

Risk management is embedded in Trust decision making and service delivery. This is supported by continually considering and assessing Trust compliance with key clinical guidance including:

- Guidance and technology appraisals from the National Institute for Health and Care Excellence (NICE).
- National Service Frameworks (NSFs).
- National Enquiries for example Confidential Inquiries.
- Patient Safety Alerts.
- Professional Guidelines for example from Royal Colleges.
- Guidelines or standards from other national/local bodies.
- Local and national audit.
- Research & Development.
- Participation in clinical trials.
- Health and Care Standards (Wales).

TRUST RISK REGISTERS

The organisation's risk profile is visible through the Trust Risk Registers. Risks are identified at the commencement of new or amended activities and through the ongoing review of existing risks. Risk assessments are undertaken to assess the impact upon the service and other stakeholders. Public Stakeholders are involved in the assessment of risk through public consultations, Patient Liaison Group representation and Community Health Council at Trust Board and Committee meetings, feedback received in respect of Patient Experience surveys and Donor Forums and learning from Concerns received from patients, donors, relatives and/or carers.

All risks are assessed and awarded a score, informed by potential impact and likelihood. Risks are escalated resulting in the highest level of risk being referred to the Executive Management Trust Board for appraisal prior to inclusion on the Trust's risk register and reported to Trust Board and relevant Trust Board Committee/s. Each risk entered onto the Trust register is given a 'target' score informed by the appetite for the risk, which is the level of risk the Trust Board is prepared to accept before action is deemed necessary to reduce it. The risk appetite is used in decision making to inform the prioritisation of actions and the resources required to mitigate risks on the Trust risk register. The system of record and for risk management is Datix. The Trust updated the module used in Datix and the revised forms in 2022.

New risks are accessed through the governance cycle; new risk are reviewed by divisional Senior Leadership/Senior Management Teams, when a risk will accepted, declined or closed. Management from that point is led by the risk lead, in conjunction with the risk owner, and where the level is such (a risk rating over 15 or over 12 for safety risks) the risk is reported through the governance cycle detailed below.

The Trust has three levels of risk training:

- **Level 1** – This training is carried out by all staff in the Trust by means on e-learning. The training sets out how to identify risk and report risk, via the Datix system via the first input form.
- **Level 2** – Training is aimed at risk leads, providing information on manage risk, initially via second input form, including risk assessments, why and how we manage risk, descriptions of risk and rating of risks. The key objective of level three training is to manage risk and follow the cycle of a risk, mitigations, action plans and regular management. Tools are included in the training package. This training is delivered online via Teams, this is a fully interactive session, including scenarios to test understanding.
- **Level 3** – The focus of this training is on governance and individual roles of Board Members and Directors in respect of risk. Leadership responsibility is key to this level of training. The training is delivered via Executive Management Board meetings and Board Development sessions.

The Risk Policy and Procedure were revised and approved in September 2022 following ongoing review through 2022. All improvement opportunities identified from the Internal Audit Report in 2021/22 were fully completed and implemented by April 2023.

The highest scored risks as at end of March 2023, governed through the March Committee and Trust Board cycle are summarised below, for access to fuller detail, including mitigating actions and controls, please review the March 2023 Trust Board Risk Paper here.

Risk Type	Division	Title	Rating (Current)	Rating (Target)
Safety	Corporate	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	12	9
Safety	Corporate	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	12	9
Safety	Corporate	Infection control - There is a risk that staff could contract COVID-19 in their working environment as a result of poor social distancing or hygiene.	12	9
Safety	Velindre Cancer Centre	Risk that patients with altered airways may not receive appropriate care from the MDT clinical team with necessary skills and competencies due to frequency of staff being required to use these competencies and their ability to train and maintain.	12	6
Quality	Welsh Blood Service	There is a risk to quality/ complaints/ audit/ GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	16	4
Performance & Service Sustainability	Transforming Cancer Services	There is a risk that the high-pressure water main at Asda, which have recently been discovered, will need to be moved, which may lead to a delay of several months to Asda's works.	16	6
Safety	Velindre Cancer Centre	There is a risk that the continuation of safe patient care may be adversely affected resulting in harm as a result of technical errors in DHCR	15	5
Performance & Service Sustainability	Velindre Cancer Centre	There is a risk that if the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025 then operational delivery of pathology services may be severely impacted resulting IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	20	5
Performance & Service Sustainability	Velindre Cancer Centre	Digital Health Care Record 118(R) - There is a risk that patient's records in WPAS will not be updated correctly or at all. Caused by a reduced level of knowledge on the actual events that have occurred and lack of access to medical records e.g. paper notes, specialist clinical systems to make the appropriate decision on what should/shouldn't not be done in the record.	20	9

Risk Type	Division	Title	Rating (Current)	Rating (Target)
		The impact being inaccurate patient records and potential errors in patient pathways.		
Compliance	Corporate	There is a risk to compliance as a result of the permanent deletion of email mailboxes for VUNHST staff who have fully left the NHS since September 2021, leading to a potential issue should those emails be required by a 3rd party investigation - e.g. COVID enquiry.	15	3
Financial Sustainability	Transforming Cancer Services	Interest Rates - There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	16	12
Workforce	Velindre Cancer Centre	Acute Oncology Service (AOS) Workforce Gaps. There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced.	15	6
Performance & Service Sustainability	Velindre Cancer Centre	Digital Health Care Record 062(R) - There is a risk that patients will still be live in Canisc at the end of the 12-week dual running period, caused by an increased number of patient treatment delays/suspensions. There will be a negative impact on service capacity with the additional need to manually migrate IRMER forms that are nearly complete or fully complete. This may further negatively impact BAU activities, such as the Mosaiq upgrade.	15	10
Performance & Service Sustainability	Velindre Cancer Centre	Number of emails medics are receiving, especially those related to clinical tasks. Due to the change in the content of the training position to include acute oncology, VCC has be unsuccessful in securing trainees, this is leading to significant gaps in the training rota. There is a national shortage for these roles	15	6
Performance & Service Sustainability	Velindre Cancer Centre	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees.	15	6
Performance & Service Sustainability	Velindre Cancer Centre	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service.	15	5

A link to the Trust Board papers for the period can be found here.

RISK APPETITE STATEMENT

The Trust faces a broad range of risks reflecting its responsibilities. The risks arising from its responsibilities can be significant. These risks are managed through detailed processes that emphasise the importance of integrity, intelligent inquiry, maintaining high quality staff and public accountability.

The Trust makes resources available to control operational risks at acceptable levels and we recognise that it is not possible or indeed necessarily desirable to eliminate some of the risks inherent in our activities. Acceptance of some risk is often necessary to foster innovation within the services for which we are responsible.

The Trust's Risk Appetite Statement was refreshed and approved at Trust Board in January 2023, and considers the most significant risks to which the Trust is exposed. It provides an outline of the approach to managing these risks. All strategic and business plans for operational areas must be consistent with this Statement. Given the range of the Trust's activities and responsibilities, it is not appropriate to make a single overarching statement of the Trust's attitude to risk. Instead, a range of risk appetite statements arising from the different areas of our work has been developed and approved by the Trust Board, in the following areas. The Risk Appetite categorisation approach is based on the Good Governance Institute (GGI) Risk Appetite for NHS Organisations Matrix.

- Safety - 1 - Minimal
- Quality - 2 - Cautious
- Compliance - 2 - Cautious
- Research & Development – 3 - Open
- Reputation & Public Confidence - 2 - Cautious
- Performance & Service Sustainability - 2 - Cautious
- Financial Sustainability - 2 - Cautious
- Workforce & Organisational Development - 3 - Open
- Partnerships & Innovation – 4 – Seek
- Information Governance – 2 – Cautious
- Environmental – 3 - Open

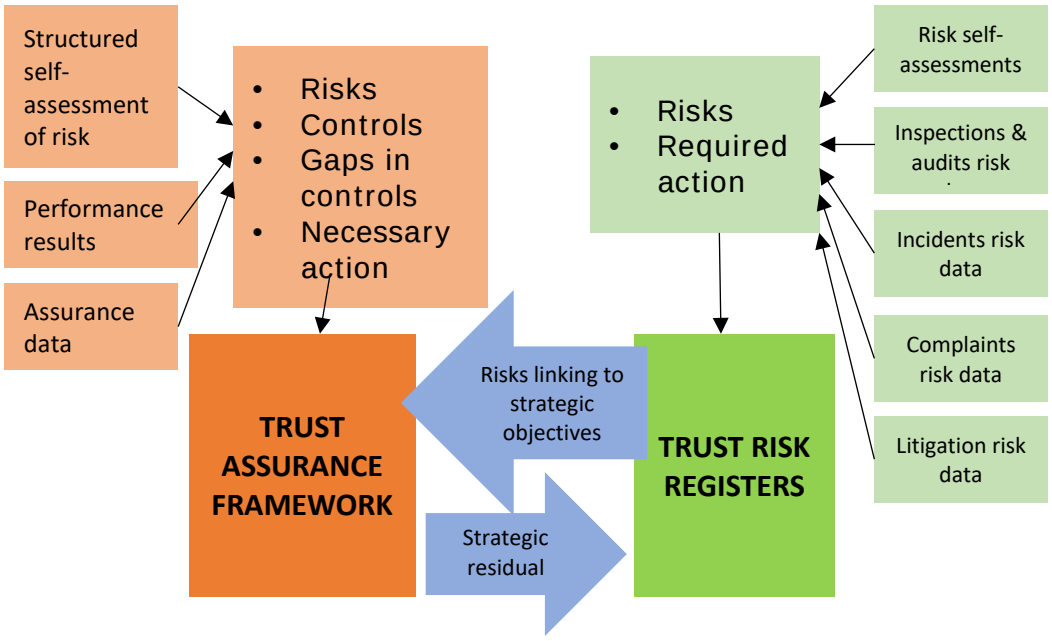
TRUST ASSURANCE FRAMEWORK (TAF)

The Audit Committee and Trust Board approved a new Board Assurance Framework (BAF) in September 2020. It was agreed to name this document and process the Trust Assurance Framework (TAF) to firstly reflect the fact that the process should be of value for the whole Trust and secondly to reflect the ambition of this framework to, in time, effectively link with both the Quality & Safety and Performance frameworks.

The TAF enables the Board to identify and understand the principal risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks, and where improvements are needed suitable action plans are in place and being delivered; and to provide an assessment of the risk to achieving the related objective.

The TAF is the key source of information that links the Velindre University NHS Trust's Strategic Objectives to risk and assurance, as demonstrated in **Figure 1**:

Figure 1: ***Information flows between the Trust Risk Register & TAF***



There is not expected to be significant movement in the articulation of the Trust's principal risks in the short-term, instead these would be reviewed and evolved in line with the organisation's strategic development cycles or in response to significant external changes.

The focus of the management of the TAF is twofold:

I. Setting out the key controls, identifying any gaps in controls and taking action to address these;

II. Setting out the sources of assurance, from first, second and third line of defence sources, and then tracking the insight that each of these sources of assurance is demonstrating against each of the risks. In addition, identifying any gaps in assurance and taking action to address these. To clarify on these terms:

- **First line of defence** – are sources of assurance from the functions that own and manage the risk.
- **Second line of defence** – are sources from the functions that oversee the day-to-day operations – e.g. Quality & Safety, Corporate / Clinical Governance.
- **Third line of defence** – are sources from functions that provide independent assurance – e.g. Internal /External Audit, Regulators, Audit Wales.

Each of the risks has an Executive owner, who is responsible for co-ordinating the actions required to improve the effectiveness of the key controls and assurance on an on-going basis. The Head of Corporate Governance works with each of the Executive owners to update the Trust Assurance Framework on a bi-monthly basis for reporting at Audit Committee, Strategic Development Committee, Quality, Safety and Performance Committee and Trust Board. The Trust has continued to further develop, mature and operationalise the TAF. This has been further enhanced by regular, informal review by Internal Audit, supported by formal Internal Audit follow up of the 2021/22 TAF report recommendations, which determined good progress is being made. Improvement opportunities identified from the Internal Audit Report will be managed by the Executive Management Board, and ongoing continued progress will be monitored via the Audit Committee by scrutiny of the Audit Action Plan.

HEALTH & CARE STANDARDS FOR WALES

The Health & Care Standards in force during 2022/23 have been in place across NHS Wales since 2015 and since this time the Trust have developed a process to help more firmly embed the Standards in the core business of Divisions and corporate teams. Work has been completed to include strengthening accountabilities and responsibilities and roles of management oversight groups in monitoring standards compliance.

The Trust has continued to drive quality improvement through 2022/23 by formally reviewing the Health and Care Standards every quarter ensuring each Standard remains firmly embedded in the core business of the Divisional and Corporate Teams.

The Divisional and Corporate teams have undertaken a comprehensive review of their compliance with the Health and Care standards during each quarter of 2022/2023, and have also ensured that the Improvement Plan has been updated. The Executive Management Board and Quality, Safety and Performance Committee have received quarterly update reports. The assessment scoring

criteria included: compliant; partial compliance or non-compliance to the national scoring criteria detailed below:

Self-Assessment Rating					
Assessment Level	1 We do not yet have a clear, agreed understandin g of where we are (or how we are doing) and what / where we need to improve	2 We are aware of the improvement s that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	3 We are developing plans and processes and can demonstrate progress with some of our key areas for improvement	4 We have well developed plans and processes can demonstrate sustainable improvement throughout the organisation / business	5 We can demonstrate sustained good practice and innovation that is shared throughout the organisations / business, and which others can learn from

A national review of the Health and Care Standards has been completed to ensure they reflect the requirements of the Wales Quality and Engagement Act (2020) and the National Quality & Safety Framework (2021) requirements. The Duty of Quality was enacted from the 1st April 2023, as such, the Health and Care Standards have been withdrawn and replaced by the Health and Care Quality Standards to align with the introduction of the Duty of Quality requirements.

The Health and Care Quality Standards provide a structure on which to implement the Duty of Quality, allowing the standards to integrate with wider Trust health systems.

GOVERNANCE & ACCOUNTABILITY ASSESSMENT / TRUST BOARD EFFECTIVENESS

The Trust Board is required to undertake an annual self-assessment of its effectiveness. The approach taken this year was to bring together the various sources of assurance, internal and external, that would support the Board in considering its overall level of maturity for the Trust in respect of good governance and Board effectiveness. At the Trust's Annual Board Governance and Effectiveness Assessment meeting on the 18 April 2023, Board members were taken through the process and concluded that the Trust's self-assessment of the overall maturity level for 2022-2023 was assessed at Level (4). This will continue to be reviewed as part of its ongoing review of Board Committee effectiveness and sources of assurance, in the pursuit of excellence, and as such is not limited to the annual review process.

Governance, Leadership & Accountability – Self Assessment	1. Do not yet have a clear, agreed understanding of where they are (or how they are doing) and what / where they need to improve.	2. Are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	3. Are developing plans and processes and can demonstrate progress with some of their key areas for improvement.	4. Have well developed plans and processes and can demonstrate sustainable improvement throughout the organisation /business.	5. Can demonstrate sustained good practice and innovation that is shared throughout the organisation/ business, and which others can learn from.
Rating				✓	

The above assessment was informed by contributions from the Interim Head and Interim Deputy Head of Internal Audit. Both were in attendance to present the Head of Internal Audit Opinion for 2022-2023, and support any queries arising from this. Opportunity was provided to comment on any observations made regarding progress since the findings of their review on the Trust Board Committee Effectiveness and the Trust Assurance Framework. Internal Audit follow up of the high and medium priority recommendations across both areas determined that good progress had been made in implementing the agreed actions, with only minor areas for improvement to be implemented. The findings of which have also helped to support the Trust's ongoing commitment to continuous improvement.

REVIEW OF EFFECTIVENESS
(ADDITIONAL SOURCES OF ASSURANCE)

As Accountable Officer, the Chief Executive has responsibility for reviewing the effectiveness of the system of internal control. The Chief Executive's review of the effectiveness of the system of internal control is informed by the work of Internal and External Auditors, the Executive Directors and other assessment and assurance reports, including the work of Healthcare Inspectorate Wales. The Chief Executive has listened to the Board on their views of the strengths and opportunities in the system of internal control and been advised by the work of the Audit Committee and other Committees established by the Board.

The Chief Executive's performance in the discharge of these personal responsibilities is assessed by the Director General of the Department of Health & Social Services/Chief Executive of NHS Wales.

At the Annual Board Governance and Effectiveness Assessment meeting (mentioned above) the Trust Board concluded an overall maturity level for 2022-2023 as Level (4); which is defined as 'having well developed plans and processes and can demonstrate sustainable improvement throughout the organisation'. The scrutiny of these arrangements is in part informed through the internal mechanisms already referred to and also through the independent and impartial views expressed by a range of bodies external to the Trust, these include:

- Children's Commissioner
- Community Health Councils
- Health & Safety Executive
- Healthcare Inspectorate Wales
- Welsh Language Commissioner
- Future Generations Commissioner
- Other accredited bodies
- Older Peoples Commissioner
- Audit Wales
- Welsh Government
- Internal Audit
  (NHS Wales Shared Services Partnership)
- Welsh Risk Pool Services
- Equality & Human Rights Commission

INTERNAL AUDIT OPINION & SCORES FOR 2022–2023

Internal audit provides the Chief Executive as Accountable Officer and the Trust Board through the Audit Committee with a flow of assurance on the system of internal control. The Chief Executive and Internal Audit agreed a programme of audit work, which was approved by the Audit Committee, and delivered in accordance with Public Sector Internal Audit Standards by the NHS Wales Audit & Assurance Services, part of the NHS Wales Shared Services Partnership. The programme of audit work is designed to focus on significant risks and local improvement priorities. The areas used to frame the 2022/23 internal audit planning process were:

1. Corporate Governance, Risk and Regulatory Compliance
2. Strategic Planning, Performance Management and Reporting
3. Financial Governance and Management
4. Clinical Governance Quality & Safety
5. Information Governance and Security
6. Operational Service and Functional Management
7. Workforce Management
8. Capital and Estates

The overall opinion by the Head of Internal Audit on governance, risk management and control is a function of this risk based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion the Head of Internal Audit has considered the impact of the audits that have not been completed.

A summary of the audits undertaken in the year and their results is outlined in the table overleaf. Improvement opportunities identified from the findings are actively being addressed by the Executive Management Board, and ongoing continued progress will be monitored via the Audit Committee by scrutiny of the Audit Action Tracker.

Substantial Assurance	Reasonable Assurance
• Digital Health Record – Implementation • Research & Development • Cyber Security	• Trust Priorities • Capital Systems • Clinical Audit • Managing Attendance at Work • Finance & Service Sustainability • Information Governance • nVCC Enabling Works (deferred from 2021/22) • Patient & Donor Experience • Performance Management Framework • Follow Up of Previous Recommendations
Limited Assurance	**Advisory/Non-Opinion**
• New Velindre Cancer Centre Mutual Investment Model	• Staff Wellbeing • nVCC Enabling Works Security Contract • Decarbonisation
No Assurance	
N/A	

The Trust has received two high priority recommendations during the reporting period, namely:

1. **Managing Attendance at Work** (MAAW) – recommendation relates to demonstrating compliance with the MAAW Policy through timely storage of absence records in the appropriate location and ensuring records contain sufficient information to justify decisions and actions.

The Trust had developed key messages for both the divisional Senior Leadership Team and Senior Management Team which has been cascaded to managers defining the process for storage of such information i.e., shared files, use of personal 'P' drives, password protected, accessibility etc. Examples of good practice and checklist examples for cascade through Divisions and use in training events has also been developed. The Trust is also in the final stages of developing the business requirement case for centralised workforce folders at the Velindre Cancer Service (in line with the Welsh Blood Service), following which this will subsequently be implemented.

A rolling programme of audits to be undertaken by Workforce & OD was agreed in September 2021 by the Executive Management Board; 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 ongoing updates to the Executive Management Board in December 2022 and March 2023.

2. **New Velindre Cancer Centre (nVCC) Mutual Investment Model Contract Management** – recommendation relates to non-compliances with the Trust Standing Orders / Standing Financial Instructions regarding the appointment of advisors or the approval / variation of adviser contracts for the nVCC. Specifically, recommendations were made around:
    - undertaking a lessons-learned exercise on contract management practices applied to date;
    - developing a governance framework for effective and compliant management of advisor and construction contracts at the nVCC and Enabling Works projects; and delegation to a suitable level (e.g. Chief Executive) of a contingency allowance (accommodated within the project budget) for the management of compensating events where NEC contracts are applied.

The Transforming Cancer Services Programme Scrutiny Sub-Committee have discussed the background of each of the contract renewals and recommended a review be undertaken by the Trust Audit Committee, to ensure that the processes undertaken to date comply with the Trust Standing Orders / Standing Financial Instructions. The Trust Audit Committee received a comprehensive review on the historical use of the above contracts and project compliance in this regard at its meeting in April 2023. The Trust Board also received an update at its April 2023 Trust Board Development session on the nVCC to provide additional assurance in respect of the nVCC project.

THE HEAD OF INTERNAL AUDIT OPINION FOR (2022–2023)

The Head of Internal Audit is satisfied that sufficient audit work has been undertaken during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards. Regular audit progress reports have been submitted to the Audit Committee during the year.

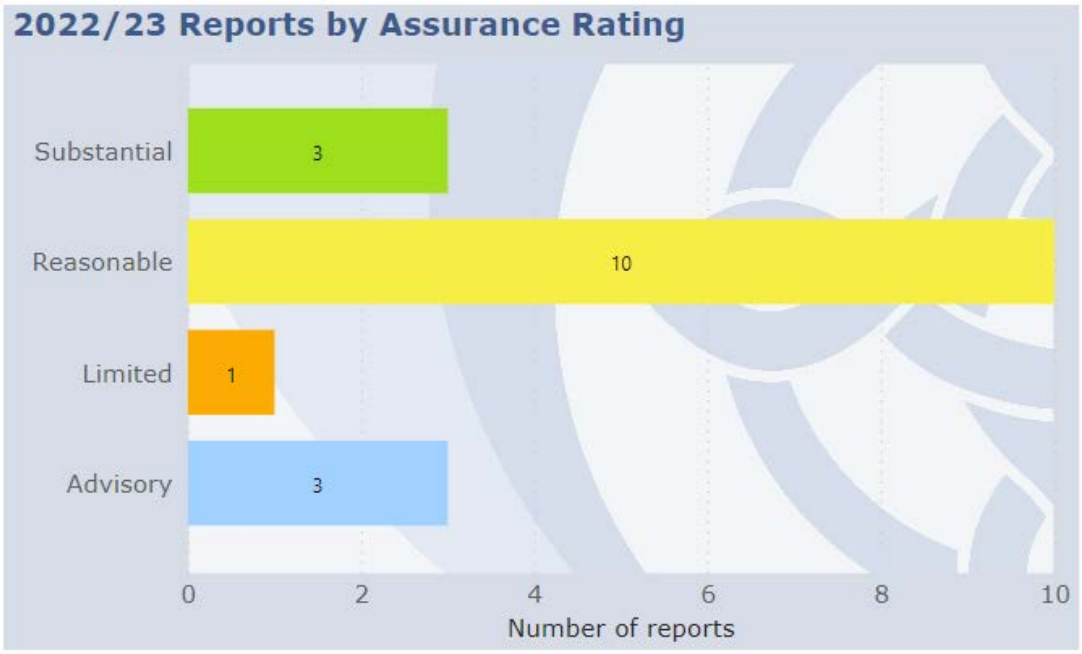
The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement.

The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below. The overall opinion was classified as Reasonable Assurance.

Reasonable assurance	 Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

In reaching this opinion the Head of Internal Audit identified that all reviews during the year concluded positively with robust control arrangements operating in some areas. From the reports issued during the year, three were allocated Substantial Assurance and ten were allocated Reasonable Assurance. One report was allocated Limited Assurance and there were no 'no assurance' reports issued. In total 17, made up of 14 assurance audits and 3 advisory (no opinion) reviews were reported during the year. The chart below presents the assurance ratings and the number of audits derived for each. Assurance opinion and action plan risk rating definitions can be found here.

Summary of audit ratings



AUDIT WALES STRUCTURED ASSESSMENT 2022 - 2023

The Trust's External Auditors, Audit Wales, 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 of their use of resources under section 61 of the Public Audit (Wales) Act 2004.

Audit Wales 2022 Structured Assessment work took place at a time when NHS bodies continued to not only address the ongoing challenges presented as a result of the pandemic, but were also seeking to recover and transform services.

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.

The main conclusions of Audit Wales 2022 Structured Assessment work are summarised below:

- Overall, 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.
- The Trust's Board and its committees continue to operate effectively and are actively using learning to drive improvement. Opportunities remain to improve the public availability of key papers and documents on the Trust's website.
    - In the Trust management response, it has set out / advised Audit Wales that it has implemented tracking to ensure the completeness and timely publication of committee agenda bundles and other key governance papers in this regard.
- 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. It would benefit from reinstating the log for tracking recommendations relating to the quality and safety of services made by external inspection and regulatory bodies.
    - In the Trust management response, it has set out / advised Audit Wales that the Quality & Safety Improvement Tracker will be received at each meeting of the Quality, Safety & Performance Committee from May 2023 onwards, together with the associated Improvement Plan using the 7 levels of assurance template. The Trust management

response also confirmed that the Trust wide Legislative & Regulatory Compliance Register is already established and received in full by the Trust Audit Committee.

- 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 time bound, they do not set out the intended outcome. In the Trust management response, it has set out / advised Audit Wales that further work will be undertaken to:

  (i.) improve the SMART elements of the objectives

  (ii). align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase 2)

- 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.
  - In the Trust management response, it has set out / advised Audit Wales that its IMTP for 2023-2026 will outline the impact / benefits of actions being taken and the process for developing the IMTP has included an assessment of actions which should be rolled forward to 2023 – 2026 reported through the Trust governance structure.
- 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.
- 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.
  - In the Trust management response, it has set out / advised Audit Wales this will be addressed in the Workforce and OD report received at the May 2023 Trust Board onwards and also as appropriate via the Trust Quality, Safety & Performance Committee Cycle of Business.
- The Trust has ambitious plans in place to harness the potential of digital to transform service delivery, but some plans remain un-costed. Furthermore, arrangements for monitoring and reporting on the benefits of digital require strengthening.
  - In the Trust management response, it has set out / advised Audit Wales that 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

- 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.

Improvement opportunities identified from the 2022 Structured Assessment work are actively being addressed by the Executive Management Board, and ongoing continued progress will be monitored via the Trust Audit Committee by scrutiny of the Audit Action Plan.

BUSINESS CONTINUITY AND EMERGENCY PREPAREDNESS

Business Continuity & Emergency Preparedness:

NHS organisations must ensure that they have in place emergency plans and business continuity arrangements that takes full account of their statutory duties under the Civil Contingencies Act 2004 and Emergency Planning Guidance issued by Welsh Government. Velindre University NHS Trust (VUNHST) including the Welsh Blood Service and Velindre Cancer Centre are required to submit an annual Emergency Planning Report setting out broadly their level of compliance in meeting these requirements and also to submit a copy of their current major incident/emergency plan for perusal. The Trust had effective emergency and business continuity arrangements in place during the financial year 2022-2023, in accordance with the Civil Contingencies Act and the Emergency Planning Guidance issued by Welsh Government. The Trust has submitted the requested documentation to Welsh Government and continues to make significant progress in its Business Continuity and Emergency Preparedness framework, which includes multi-faceted planning, underpinned by robust risk management arrangements. The changing environment of risk results in the strategies and plans being reviewed regularly and in line with the National and all Wales Risk Registers. Emerging threats are considered in the development and enhancement of risk mitigation strategies and the organisations response mechanisms. These plans are commensurate with the level of risk the Trust anticipates exposure to.

Co-operation and Information Sharing:

The Trust continues to work closely with a wide range of partners across a number of varying themes, integrated with NHS Wales, Local Authorities, Welsh Government and the Local Resilience Forum its partners with and key stakeholders. In addition, the Welsh Blood Service continues to work closely with other UK Blood services to further enhance the mutual aid arrangements between services to maintain the continuity and safety of the blood supply chain.

Training and Exercising:

The Trust continues to engage with Welsh Government Emergency Planning Advisory Group and Local Resilience Forums around key strategies for workload including internal and external training and exercising. Engagement in multidisciplinary exercises allows the Trust to encompass lessons identified and to align to wider health emergency planning with the aim to further improve current procedures.

Work Programme 2023/2024:

During 2023/2024, the Trust plans to continually review and enhance its business continuity management system to ensure alignment with current best practice guidelines and to ensure the Trust is prepared in any future emergency planning and business continuity arrangements.

INTEGRATED MEDIUM TERM PLAN (IMTP) 2023/2024 – 2025/2026

We are an ambitious organisation striving to provide services which are recognised as outstanding by the people who use them, the people who work in them and by our peer organisations.

Velindre University NHS Trust purpose is to 'improve lives' and we have a vision of 'excellent care, inspirational learning and healthier people'.

Our guiding principles are founded upon the Well-being of Future Generations Act (Wales) 2015.

Our purpose and vision are supported by a clear set of five Strategic Goals to be achieved through a focused set of key deliverables, which provide the framework for our IMTP over the coming three years:

Destination 2032: Our View of the Future

Our Purpose: To Improve Lives

Our Vision: Excellent Care, Inspirational Learning, Healthier People

Our Strategic Goals

The NHS in Wales is a planned system and each Health Board and Trust is required to have a fully costed three-year rolling Integrated Medium Term Plan. In accordance with the set statutory duty, we have submitted our IMTP, covering the period 2023/24 – 2025/26, to the Welsh Government. This was approved by the Velindre University NHS Trust Board on 30th March 2023.

EQUALITY & DIVERSITY

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and inclusion are complied with.

The control measures include:

- Trust Strategic Equality Plan and Objectives.
- Trust Gender Pay Gap Report.
- Trust Annual Equality Monitoring Report.
- Equality reports to Quality, Safety & Performance Committee on the Trust's Equality Objectives and Actions.
- Reports to the Equality and Human Rights Commissions' enquiries.
- Report to the Welsh Government Equalities Team.
- Provision of evidence to the Health Care Standards Audit, specifically Standard 2.
- Integrated Equality Impact Assessments.

CONCLUSION

As indicated throughout this statement, the need to continue to develop and evolve as we move forward from the COVID-19 pandemic, will be with the organisation and wider society throughout 2023-2024 onwards. I will ensure our Governance Framework considers and responds to this need, whilst also continuing to optimise the learning and development opportunities that have arisen in response to the various stages of the pandemic.

The system of internal control has been in place for the financial year ended 31 March 2023 and up to the date of approval of the 2022-2023 Annual Report and Accounts.

There have been no significant governance issues identified during this period.

Signed by:

Mr. Steve Ham
Chief Executive

Date: xx/xx/2023

APPENDIX 1 – GOVERNANCE STATEMENT – TRUST BOARD & COMMITTEE ACTIVITY 2022-2023

The table below outlines the key highlights and activity considered by the Trust Board and its Committees during 2022-2023, please note this is not an exhaustive list.

Meeting:	Meeting Dates:	Activity:
Velindre University NHS Trust - Public Trust Board meeting. Meeting Agendas, Minutes and Papers are available on the Trust Internet site here: https://velindre.nhs.wales/about-us/trust-board/public-trust-board-meetings/	• 26.05.2022 • 14.06.2022 • 28.07.2022 • 29.09.2022 • 24.11.2022 • 31.01.2023 • 30.03.2023 All meetings were quorate.	High level summary/headlines of key topics received by the Trust Board during 2022-2023: • Chair and CEO Update Reports • Chair's Urgent Actions Reports • Commitment of Expenditure Exceeding Chief Executive's Limit • Policy Update Reports • Documents 'Sealed' Reports • Board Committee Highlight & Annual Reports • Welsh Health Specialist Services Committee & Emergency Ambulance Services Committee Joint Committee Briefings • Shared Services Partnership Committee Assurance Report • Performance Reports • Financial Reporting • Annual Report and Accounts 2021/22 • Trust Risk Register and Trust Assurance Framework • Development of Integrated Medium Term Plan & Progress Delivery Reports • Equality, Diversity & Inclusion Ambassadors Showcases • Developing our Future Strategic Direction 2022 – 2032: enabling strategies (sustainability, people, digital and estates) • Revisions to Velindre University NHS Trust Model Standing Orders and Standing Financial Instructions • Infected Blood Inquiry Reporting • Wales Infected Blood Support Service (WIBSS) Annual Report

Meeting:	Meeting Dates:	Activity:
		• Integrated Radiotherapy Solution Full Business Case • Radiotherapy Satellite Centre Full Business Case
Advisory Consultant Appointments Committee	Panels were held: • 14/06/22 • 20/07/22 • 23/02/23	As and when required the Advisory Consultant Appointment Committee meet to manage the arrangements for appointments to NHS Consultant posts within the Trust.
Trust Audit Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here: https://velindre.nhs.wales/about-us/audit-committee/	• 03.05.2022 • 13.06.2022 • 19.07.2022 • 04.10.2022 • 12.01.2023 • 25.04.2023 All meetings were quorate.	The purpose of the Audit Committee is to: Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales. Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how its system of assurance may be strengthened and developed further. The Audit Committee Annual Report which outlines the activity of the Committee for the year ending 31 December 2022 was approved by the Audit Committee on 12 January 2023 and is available on the Trust Internet site here:
NHS Wales Shared Services Partnership Committee (SSPC) Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 19.05.2022 • 21.07.2022 • 22.09.2022 • 19.01.2023 • 23.03.2023 All meetings were quorate.	The SSPC has been established for the purpose of exercising Velindre's functions in relation to Shared Services, including the setting of policy and strategy and the management and provision of Shared Services to HBs, Trusts and Special Health Authority in Wales.

Meeting:	Meeting Dates:	Activity:
NHS Wales Shared Services Partnership Audit Committee (NWSSP) Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 05.04.2022 • 29.06.2022 • 13.07.2022 • 11.10.2022 • 24.01.2023 All meetings were quorate.	The NWSSP Audit Committee Annual Review was received at its July 2022 meeting and is available here.
Charitable Funds Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 17.05.2022 • 20.09.2022 • 19.01.2022 • 21.03.2023 All meetings were quorate.	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. The purpose of the Committee "is to make and monitor arrangements for the control and management of the Trust's Charitable Funds". The Charitable Funds Committee Annual Report for 2022/23, which outlines the activity of the Committee for the year ending 31 March 2023, will be received by the Committee for approval in June 2023.
Local Partnership Forum (LPF)	• 05/05/2022 • 05/07/2022 • 06/09/2022 • 08/11/2022 • 07/03/2023 All meetings were quorate.	The purpose of the Local Partnership Forum (LPF) is: To provide a formal mechanism where the Trust, as employer and trade unions / professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the Trust's workforce. It is the forum where the Trust and staff organisations will engage with each other

Meeting:	Meeting Dates:	Activity:
		to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters. The Trust may specifically request advice and feedback from the LPF on any aspect of its business and the LPF may also offer advice and feedback even if not specifically requested by the Trust. The LPF may provide advice to the Board: o In written advice or, o In any other form specified by the Board. The Local Partnership Forum Annual Report for 2022/23, which outlines the activity of the Committee for the year ending 31 March 2023 is due to be received at its June 2023 meeting.
Quality, Safety & Performance Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 12.05.2022 • 14.07.2022 • 15.09.2022 • 10.11.2022 • 17.01.2022 • 16.03.2022 All meetings were quorate.	The purpose of the Quality, Safety and Performance Committee is to provide: Evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the: quality, safety and performance of healthcare; all aspects of workforce; digital delivery and information governance; and Assurance to the Board in relation to the Trust's arrangements for safeguarding and improving the quality, safety and performance of patient and service user centred healthcare, workforce matters, digital delivery and information governance in accordance with its stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales.

Meeting:	Meeting Dates:	Activity:
		The Quality, Safety & Performance Committee Annual Report for the year ending 31 March 2023 will be approved at the July 2023 Committee.
Strategic Development Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 16.05.2022 • 07.07.2022 • 13.10.2022 • 08.12.2022 • 07.02.2023 • 24.03.2023 All meetings were quorate.	The purpose of the Strategic Development Committee is to provide: Evidence based and timely advice to the Board to assist it in discharging its functions and responsibilities with regard to the: • strategic direction • strategic planning and related matters • organisational development • digital services, estates and other enabler services • sustainable development and the implementation of strategy through the spirit and intention of the Well Being of Future Generations Act • investment in accordance with Value-based healthcare Assurance to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further. The Strategic Development Committee Annual Report which outlines the activity of the Committee for the year ending 31 March 2022 will be approved at its July 2023 Committee.

Meeting:	Meeting Dates:	Activity:
Remuneration Committee	• 28/04/2022 • 22/09/2022 • 25/10/2022 • 09/02/2023 All meetings were quorate.	The purpose of the Remuneration Committee is to provide: • ***advice*** to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Assembly Government; and • ***assurance*** to the Board in relation to the Trust's arrangements for the remuneration and terms of Service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales. And to perform certain, specific functions on behalf of the Board.
Research, Development & Innovation (RDI) Sub-Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 07.04.2022 • 21.07.2022 • 15.11.2022 • 28.02.2023 All meetings were quorate.	The purpose of the RD&I Sub-Committee is to provide: • Strategy and policy oversight for Innovation and Research activities at the Trust and advise on and monitor performance in these areas. • Promotion and encouragement of an Innovation and Research ethos and culture which is integral to the Trusts vision, mission and values. • Evidence based timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regards to the quality and safety of Innovation and Research activity. In the relation to research this includes activity carried out within the Trust both as a research sponsor and host organisation. • Assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the, and the EU Clinical Trials Directive 2004 as amended from time to time. • Foster collaboration and make recommendations on adoption and dissemination.

Meeting:	Meeting Dates:	Activity:
		• Consideration of relevant matters with reference to the parameters identified for risk appetite in relation to research, development and innovation as set by the Board.
Transforming Cancer Services Programme Scrutiny Sub-Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 04.05.2022 • 19.05.2022 • 21.06.2022 • 19/07/2022 • 22.09.2022 • 18.10.2022 • 17.11.2022 • 26.01.2023 • 23.03.2023 All meetings were quorate.	The purpose of the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee is to: • Provide assurance that the leadership, management and governance arrangements are sufficiently robust to deliver the outcomes and benefits of the programme. • Scrutinise the progress of the programme and provide the Trust Board with assurance that implementation is effective, efficient and within the budget available. • Undertake any other scrutiny activity relating to the TCS Programme as directed by the Trust Board or Senior Responsible Owner (SRO). • Seek advice and guidance from appropriate Technical Advisors as well as the MIM Transactor (if relating to the nVCC Project) to assist the Committee with their scrutiny of the TCS Programme. • Provide assurance to the Trust Board on all aspects of the TCS Programme in relation to approvals sought on all decisions reserved for the full Board. • Receive all audit, gateway and assurance reviews pertaining to the programme or its constituent projects and provide assurance (or otherwise) to the Trust that the programme is being delivered in accordance with all professional, financial and Trust standards. • Provide assurance to the Trust Board and support to the Senior

Meeting:	Meeting Dates:	Activity:
		Responsible Officer in signaling the TCS closure activities once it has met its objectives. • Where appropriate, the Committee will advise the Trust Board and the Accountable Officer on where, and how, its system of assurance in relation to the TCS Programme may be strengthened and developed further.

APPENDIX 2–Board Member Attendance

Trust Board & Committee Meetings 2022- 2023

NAME	POSITION & AREA OF REPRESENTATION	BOARD & COMMITTEE MEMBERSHIP & RECORD OF ATTENDANCE	CHAMPION ROLE
Professor Donna Mead, OBE	Trust Chair	• Trust Board **(Chair) 7/7** • Charitable Funds Committee **(Chair) 4/4** • Remuneration Committee **(Chair) 4/4** • Public Quality, Safety & Performance Committee **5/6** • Public Strategic Development Committee **4/6** • Private Strategic Development Committee **1/3** • Research, Development & Innovation Sub-Committee **4/4** • Public TCS Programme Scrutiny Sub-Committee **8/9** • Private TCS programme Scrutiny Sub-Committee **10/11**	Trust Champion for Armed Forces and Veterans, University Trust
Stephen Harries	Vice-Chair	• Trust Board **6/7** • Public Strategic Development Committee **(Chair) 5/6** • Private Strategic Development Committee **(Chair) 3/3** • Public TCS Programme Scrutiny Sub-Committee **(Chair) 7/10** • Private TCS programme Scrutiny Sub-Committee **(Chair) 9/11** • Public Quality, Safety & Performance Committee **5/6** • Remuneration Committee **4/4**	Information Governance, Information Management and Technology
Professor Andrew Westwell	Independent Member	• Trust Board **7/7** • Research, Development & Innovation Sub-Committee **(Chair) 4/4** • Public Strategic Development Committee **5/6**	University Representative

NAME	POSITION & AREA OF REPRESENTATION	BOARD & COMMITTEE MEMBERSHIP & RECORD OF ATTENDANCE	CHAMPION ROLE
		• Private Strategic Development Committee **2/3**	
Gareth Jones	Independent Member	• Trust Board **6/7** • Public Strategic Development Committee **5/6** • Private Strategic Development Committee **2/3** • Audit Committee **6/6** • Public TCS Programme Scrutiny Sub-Committee **7/10** • Private TCS Programme Scrutiny Sub-Committee **8/11**	Legal
Hilary Jones	Independent Member	• Trust Board **6/7** • Public Quality, Safety & Performance Committee **4/6** • Charitable Funds Committee **4/4** • Charitable Funds Investment Performance Review Sub-Committee **2/2** • Public TCS Programme Scrutiny Sub-Committee **9/10** • Private TCS programme Scrutiny Sub-Committee **11/11**	Estates and Planning
Vicky Morris	Independent Member	• Trust Board **5/7** • Public Quality, Safety & Performance Committee **(Chair) 5/6** • Audit Committee **6/6** • Research, Development & Innovation Sub-Committee **4/4**	Quality and Safety
Martin Veale	Independent Member	• Trust Board **5/7** • Charitable Funds Committee **4/4** • Charitable Funds Investment Performance Review Sub-Committee **(Chair) 2/2** • Audit Committee **5/6** • Remuneration Committee **3/4**	Finance, Audit and Governance
Steve Ham	Chief Executive	• Trust Board **4/7** • Public Quality, Safety & Performance Committee **4/6**	Chief Executive Accountable Officer

NAME	POSITION & AREA OF REPRESENTATION	BOARD & COMMITTEE MEMBERSHIP & RECORD OF ATTENDANCE	CHAMPION ROLE
		• Public Strategic Development Committee **5/6** • Private Strategic Development Committee **3/3** • Charitable Funds Committee **3/4** • Charitable Funds Investment Performance Review Sub-Committee **0/2** • Remuneration Committee **3/4** • Research, Development & Innovation Sub-Committee **1/4** • Public TCS programme Scrutiny Sub-Committee **4/10** • Private TCS programme Scrutiny Sub-Committee **5/12** • Local Partnership Forum **1/5**	
Carl James	Executive Director of Strategic Transformation, Planning, and Digital	• Trust Board **7/7** • Public Quality, Safety & Performance Committee **4/6** • Public Strategic Development Committee **5/6** • Private Strategic Development Committee **3/3** • Public TCS Programme Scrutiny Sub-Committee **9/10** • Private TCS programme Scrutiny Sub-Committee **11/12** • Audit Committee **1/6** (Acting CEO) • Remuneration Committee (Acting CEO) **1/4**	Strategic Transformation, Planning, Digital & Estates.
Jacinta Abraham	Executive Medical Director	• Trust Board **7/7** • Research, Development & Innovation Sub-Committee **4/4** • Public Quality, Safety & Performance Committee **4/6** • Public TCS Programme Scrutiny Sub-Committee **2/10** • Private TCS programme Scrutiny Sub-Committee **2/12** • Public Strategic Development Committee **4/6**	Medical Director and Research

NAME	POSITION & AREA OF REPRESENTATION	BOARD & COMMITTEE MEMBERSHIP & RECORD OF ATTENDANCE	CHAMPION ROLE
		• Private Strategic Development Committee **1/3** • Charitable Funds Committee **2/4** • Audit Committee **3/6**	
Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Science	• Trust Board **5/7** • Public Quality, Safety & Performance Committee **4/6** • Public Strategic Development Committee **4/6** • Private Strategic Development Committee **1/3** • Public TCS Programme Scrutiny Sub-Committee **2/10** • Private TCS programme Scrutiny Sub-Committee **2/12** • Research, Development & Innovation Sub-Committee **3/4** • Local Partnership Forum **1/5**	Quality, Safety and Nursing
Sarah Morley	Executive Director of Organisational Development & Workforce	• Trust Board **6/7** • Public Quality, Safety & Performance Committee **4/6** • Public Strategic Development Committee **5/6** • Private Strategic Development Committee **2/3** • Remuneration Committee **4/4** • Local Partnership Forum **(Chair) 5/5**	Organisational Development and Workforce
Matthew Bunce	Executive Director of Finance	• Trust Board **7/7** • Audit Committee **6/6** • Public Quality, Safety & Performance Committee **5/6** • Public Strategic Development Committee **6/6** • Private Strategic Development Committee **3/3** • Charitable Funds Committee **4/4**	Finance and Charitable Funds

NAME	POSITION & AREA OF REPRESENTATION	BOARD & COMMITTEE MEMBERSHIP & RECORD OF ATTENDANCE	CHAMPION ROLE
		• Public TCS Programme Scrutiny Sub-Committee **7/10** • Private TCS programme Scrutiny Sub-Committee **10/12** • Charitable Funds Investment Performance Review Sub-Committee **2/2** • Research, Development & Innovation Sub-Committee **3/4** • Local Partnership Forum **2/5**	

APPENDIX 3 – Ministerial Directions and Welsh Health Circulars

Ministerial Directions and Welsh Health Circulars	Date / Year of Adoption	Executive Lead(s)	Status
The Wales Infected Blood Support Scheme (Amendment) (No. 2) Directions 2022	8 December 2022	Chief Operating Officer	This Ministerial Direction has been enacted.
Local health boards and NHS Trusts reporting on the introduction of new medicines into the National Health Service in Wales Directions 2023	24 March 2023	Executive Medical Director	This Ministerial Direction has been enacted.
(WHC/2022/09) Prioritisation of COVID-19 patient episodes by NHS Wales clinical coding departments	04 April 2022	Director of Strategic Transformation, Planning & Digital and Chief Operating Officer.	This Ministerial Direction has been enacted.
(WHC/2022/015) Changes to the vaccine for the HPV immunisation programme	01 June 2022	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.
(WHC/2022/016) The National Influenza Immunisation Programme 2022 to 2023.	01 June 2022	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.
(WHC/2022/002) NHS Wales national clinical audit and outcome review plan annual rolling programme for 2022 to 2023	14 June 2022	Executive Medical Director	This Ministerial Direction has been enacted.
(WHC/2022/12) Donation and transplantation plan 2022-2026	16 June 2022	Chief Operating Officer	This Ministerial Direction has been enacted.
(WHC/2022/18) Suspected cancer pathway: guidelines	30 June 2022	Chief Operating Officer	This Ministerial Direction has been enacted.
(WHC/2022/020) Never events: policy and incident list July 2022	22 July 2022	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.

Ministerial Directions and Welsh Health Circulars	Date / Year of Adoption	Executive Lead(s)	Status
(WHC/2022/021) National optimal pathways for cancer	28 July 2022	Executive Director of Nursing, Allied Health Professions and Health Science. Executive Medical Director, Chief Operating Officer and Director of Strategic Transformation, Planning & Digital.	This Ministerial Direction has been enacted.
(WHC/2022/023) Changes to the vaccine for the HPV immunisation programme (WHC/2022/023)	09 September 2022	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.
(WHC/2022/011) COVID-19 patient testing framework	22 September 2022	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.
(WHC/2022/026) Approach for respiratory viruses: technical guidance for healthcare planning	11 October 2022	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.
(WHC/2022/031) Reimbursable vaccines and eligible cohorts for the 2023 to 2024 NHS seasonal influenza (flu) vaccination programme	08 December 2022	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.
(WHC/2022/035) Influenza (flu) vaccination programme deployment ‘mop up’ 2022 to 2023 (WHC/2022/035)	22 December 2022	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.
(WHC/2023/04) COVID-19 spring booster 2023	08 March 2023	Executive Director of Nursing, Allied Health Professions and Health Science.	This Ministerial Direction has been enacted.

FINANCIAL ACCOUNTABILITY REPORT

The Trust continues to operate in a challenging financial environment like all organisations in NHS Wales, which continued to be difficult in 2022/2023 as there were significant increases in energy costs and recovery from the COVID-19 pandemic still required significant additional expenditure. However, despite these challenges, opportunities to make efficiency savings and identify recurring reductions in costs whilst maintaining and improving services are sought wherever possible by Directors, finance teams and staff across the organisation.

The Core Trust Services incurred additional revenue spend of £4.273m and capital spend of £nil (2021/2022 revenue spend of £11.521m and capital spend of £0.675m) to establish additional capacity, support mass vaccination, provide PPE, undertake enhanced cleaning etc in its response to the pandemic. Welsh Government and Commissioners through protected LTA activity growth income provided the Trust with funding to cover these COVID-19 related issues which ensured they did not impact on the Trust meeting the key target of its revenue expenditure not exceeding income.

Despite these challenges, the Trust was able to achieve all three financial targets set by Welsh Government in 2022/2023. The Trust has submitted a balanced financial plan for 2023/2024 to 2025/2026 which includes a significant amount of risk, so delivery of the key target of revenue expenditure remaining within income will be difficult to achieve in 2023/2024, and the foreseeable future, as the Trust continues to respond to the backlog demand in recovering from the pandemic, and fund significantly increased energy costs and general price inflation.

The Trust remains committed to providing high value, quality and safe care with the best possible outcomes for its patients, while striving to deliver this through efficient and effective services, and therefore seeking opportunities to make efficiency savings and identify recurring reductions in costs will continue to be a priority focus for the organisation.

FINANCIAL TARGETS

The Trust has met all three of its financial targets for the year ended 31st March 2023:

- Breakeven duty **-** The Trust achieved a revenue surplus of £0.076m in 2022/2023 (2021/2022: surplus of £0.041m; 2020/2021 surplus of £0.038m), resulting in a surplus of £0.155m over a three year period. The Trust has therefore achieved its statutory financial duty to achieve financial breakeven over a rolling three year period.

- Duty to prepare a 3 year integrated plan –The Trust submitted a 2022-2025 integrated plan in accordance with the planning framework and has therefore met its statutory duty to have an approved financial plan.

- Creditor payments - The Trust is required to pay 95% of the number of non- NHS bills within 30 days of the receipt of goods or a valid invoice (whichever is the later). The Trust has met this target, paying 95.6% (2021/2022: 95.7%) within the required time.

The Trust ordinarily would have four financial targets to meet: the fourth being the External Finance Limit (EFL). The Welsh Government temporarily removed this target in 2019/2020, in response to the pandemic, and are expected to reintroduce it in 2023/2024.

FEES & CHARGES - AUDITOR REMUNERATION

Fees paid to Audit Wales for their statutory audit and performance audit work in 2021 - 2022 were £239,000 in total by the Trust, this included the £15,000 for the audit of the Trust's Charity.

MATERIAL REMOTE CONTINGENT LIABILITIES

The Trust hosts the Welsh Risk Pool (WRP) as part of NHS Wales Shared Services Partnership (NWSSP). The WRP returns from Welsh Health Organisations estimate that in 2022/2023 the Trust has remote contingent liabilities of £103m (2021/2022: £60m) which relate to potential litigation claims against NHS Wales that could arise in the future due to known incidents. Due to the nature and uncertainty of these potential claims, no provision has been made for them within the accounts.

LONG TERM EXPENDITURE TRENDS

	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
	£000	£000	£000	£000	£000
Total Revenue	**525,607**	**572,642**	**848,405**	**1,044,074**	**965,663**
Pay	160,551	182,684	242,072	294,020	404,977
Non Pay	352,075	373,015	587,320	738,544	556,429
Depreciation	16,466	17,186	17,554	10,222	11,755
Total Expenditure	**529,092**	**572,885**	**846,946**	**1,042,786**	**973,161**
Non-operating revenue and costs	**3,295**	**440**	**(207)**	**(953)**	**10,324**
Total consolidated surplus / (deficit)	**(190)**	**197**	**1,252**	**335**	**2,826**

The table above includes the income and expenditure of the Trust's charitable fund and assets that have been donated to the Trust, and, in the case of 2021/2022, assets that have been donated by NWSSP. The Trust's annual surplus / (deficit) excluding the charitable fund and donated assets is shown below:

	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
	£000	£000	£000	£000	£000
Surplus / (deficit) excluding charitable fund and donated assets	**31**	**24**	**38**	**41**	**76**

Notes

- During 2018/2019 the Wales Workforce Education & Development Services (WEDS), which was part of the NHS Wales Shared Services Partnership (NWSSP), was transferred from the Trust into the newly established Health Education & Improvement Wales (HEIW). The transfer of WEDS resulted in a significant reduction in the income and expenditure reported within the above table, but had no impact on the surplus / deficit for the year.
- During 2019/2020 two new all Wales services were established within NWSSP - the Medical Examiner Scheme and the General Medical Practice Indemnity Scheme.
- During 2020/2021 a new All Wales service was established within NWSSP – the Collaborative Bank Partnership; and two existing services commenced expansion – the Single Lead Employer Scheme and the General Medical Practice Indemnity Scheme to include the first phased intake to the Existing Liability Scheme.

- 2021/2022 saw the NHS Wales Informatics Service (NWIS), transition out of the Trust on 1st April 2021 to the newly established Special Health Authority, Digital Health & Care Wales (DHCW). NWSSP continued expansion of the Single Lead Employer Scheme and established a new All Wales service – the All Wales Laundry Service.
- During 2022/2023 NWSSP completed a phased rollout of all core and specialty medical trainees in NHS Wales via the Single Lead Employer Scheme.

MODERN SLAVERY ACT 2015
TRANSPARENCY IN SUPPLYCHAINS STATEMENT 2022/2023

This statement is made to comply with Section 54 of the Modern Slavery Act 2015 and the Welsh Government's Code of Practice: Ethical Employment in Supply Chains. The Statement sets out the steps that Velindre University NHS Trust has taken and is continuing to take, to make sure that modern slavery and / or human trafficking is not taking place within the Trust or its supply chains during the year ending 31st March 2023.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero-tolerance approach to any form of modern slavery (slavery, servitude, human trafficking and forced labour). We are committed to acting ethically and with integrity and transparency in all business activity and to establish effective systems and controls, to safeguard against any form of modern slavery occurring within the Trust's supply chains.

The Trust is also fully committed to complying with its legal obligations. In doing so, it is committed as an NHS employer, to eradicate modern slavery and human trafficking, by combating unlawful and unethical employment practices and to support those affected.

The Trust will not undertake any employment practices that;

- Support modern slavery and human rights abuses;
- Support or abet the operation of blacklist / prohibited lists;
- Facilitate false self-employment;
- Permits the use of unfair umbrella schemes;
- Provide employees or workers with zero hours contracts; and
- Facilitate the payment of salaries which are lower than the National Living Wage.

Current Policies and Initiatives

The Trust is fully aware of its responsibilities towards patients, donors, service users, employees and the local community, and expects all employees and suppliers to act ethically and with integrity, in all our business relationships.

The Trust takes the following steps, to ensure that there is no modern slavery or human trafficking in our supply chains or in any part of our business:

People

- The Trust is fully compliant with the six NHS pre-employment check requirements, to verify that applicants meet the preconditions of the role they are applying for. This includes a right to work in the UK check;
- The Trust has a robust IR35 policy and processes in place, which ensures that there is no unfair use of false self-employed workers or workers being engaged under umbrella schemes. This process ensures the fair and appropriate engagement of all workers and prevents individuals from avoiding paying Tax and National Insurance contributions.
- The Trust does not engage or employ employees or workers on Zero Hours Contracts. The Trust does employ Bank Staff, but these staff are provided with the opportunity to apply for substantive posts should they wish to.
- The Trust pays our lowest paid employees on Pay Band 2 (the lowest NHS Wales pay band). This salary is compliant with the National Living Wage.
- The Trust has an Equality and Diversity Policy and a range of processes and procedures which ensures that no potential applicant, employee or worker engaged by the Trust is in any way unduly disadvantaged in terms of pay, employment rights, employment, training and development and career opportunities;
- In Trust has a Working in Confidence platform that allows staff to raise and resolve concerns confidentially
- The Trust has in place a range of workforce policies e.g. Respect and Resolution Policy, Grievance Policy, Dignity at Work Procedure, Violence, Domestic Abuse and Sexual Violence in the Workplace; etc. Our policies enable our employees to raise concerns about poor working practices.
- The Trust complies fully with the Transfer of Undertaking (Protection of Employment) Regulations ensuring that Trust employees that may be required to transfer to a new organisation, will retain their current NHS Terms and Conditions of Service; and
- The Trust does not make use of blacklist / prohibited list information.

Procurement and our Supply Chain

- The Trust's Procurement Team operates within the current UK and NHS procurement regulations and includes a mandatory exclusion question regarding the Modern Slavery Act 2015.
- The Trust's NWSSP Supplier Policy sets out the manner in which we behave as an organisation and how we expect procurement employees and suppliers to act.
- The Trust's Procurement Team's approach to procurement and our supply chain includes:
    - Ensuring that our suppliers are carefully selected through robust supplier selection criteria/processes;
    - Requiring that the main contractor provides details of its sub- contractor(s), to enable the Procurement Team on behalf of the Trust to check their credentials;
    - Randomly request that the main contractor provide details of its supply chain;
    - Ensuring invitation to tender documents contain a clause on human rights issues;
    - Ensuring invitation to tender documents also contain clauses giving the Trust the right to terminate a contract for failure to comply with labour laws;
    - Using a Supplier Selection Questionnaire which includes a section on Modern Day Slavery;
    - Trust staff must contact and work with the Procurement Team when looking to work with new suppliers, to ensure that appropriate checks can be undertaken;
    - Ensuring supplier adherence to the Trust and NHS Wales values. We are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers /contractors to be compliant;

- Assurances are sought from suppliers, via the tender process, that they do not make use of blacklists/prohibited lists. The Trust is also able to provide confirmation and assurances that the Trust does not make use of blacklist/prohibited list information.
- The Transparency in Supply Chain (TISC) Report – Modern Slavery Act (2015) compliance tracker is used, through contracts procured by NWSSP Procurement Services on the Trust's behalf.

Training

- Advice and training about modern slavery and human trafficking is provided to employees through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures and our safeguarding lead. The Trust is exploring new ways to continuously increase awareness within our organisation and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking, in our supply chains and in our business.

Policies and Initiatives 2022 /2023

In the forthcoming year, the Trust is committed to ensuring that modern slavery and / or human trafficking is not taking place within our organisation or supply chain during the year ending 31st March 2023.

REMUNERATION & STAFF REPORT

The details of the Remuneration Relationship are reported on page 97 of the Accountability Report, and note 10.6 of the Annual Accounts.

The pay and terms and conditions of employment for the Executive Team and senior managers have been and will be determined by the Velindre University NHS Trust Remuneration and Terms of Service Committee, within the framework set by the Welsh Government. The Remuneration and Terms of Service Committee also considered and approved applications relating to the voluntary early release scheme. The Trust Remuneration Committee members are Independent Members of the Board and a Trade Union Representative. The Committee is chaired by the Trust Chair. Details of the membership of the Remuneration & Terms of Service Committee are captured on pages 8-12 of the Directors' Report section of this report.

Existing public sector pay arrangements apply to all staff including members of the Executive Team. All members of the Executive Team are on pay points and not pay scales. The performance of members of the Executive Team is assessed against personal objectives and against the overall performance of the Trust. The Trust does not operate a performance related pay scheme.

All Executive Directors have the option to have a lease car, under the terms of the Trust's lease car agreement.

The Chief Executive and Executive Directors are employed on permanent contracts, which can be terminated by giving due notice unless for reasons of misconduct.

There have been no payments to former Executives or other former senior managers during the year.

The remuneration report is required to contain information about senior managers' remuneration. The senior management team consists of the Chief Executive, the Executive Directors and the Independent Members (Non-Executive Directors), the Chief Operating Officer and the Director of Corporate

Governance / Board Secretary / Chief of Staff. Full details of senior managers' remuneration are shown later in the table that starts on page 90.

The totals in some of the following tables may differ from those in the Annual Accounts as they represent staff in post as at 31st March 2023 whilst the Annual Accounts (note 10.2) shows the average number of operational employees during the year.

Transparency of senior remuneration in the devolved Welsh Public Sector – ANNEX 10.

Guide to Tackling Unfair Employment Practices and False Self-Employment -
https://gov.wales/docs/dpsp/publications/valuewales/170620-unfair-employment- en.pdf - ANNEX 10

STAFF COMPOSITION BY SEX

A breakdown of the workforce by sex is set out in the table below. This figure represents the composition as at 31st March 2023. To note it excludes those in Bank, Locum and Honorary positions.

*FTE – Full-time Equivalent

Sex	Headcount	FTE*	% of Headcount
Female	1,235	1,075.83	75.26%
Male	406	385.39	24.74%
Grand Total	**1,641**	**1,461.23**	**100%**

A breakdown of the Trust Executive Directors and Senior Managers by sex is set out in the table below. This figure represents the composition as at 31st March 2023. The data confirms that there are more female than male Trust Executive Directors and Senior Managers. Female employees are employed in five out of the eight Trust Executive Directors and Senior Manager posts.

Job Title	Sex	Headcount	FTE*	% of Headcount
Chief Executive Officer	Male	1	1	12.50%
Chief Operating Officer	Female	1	1	12.50%
Executive Director of Finance	Male	1	1	12.50%
Executive Medical Director	Female	1	1	12.50%
Executive Director of Nursing, AHP and Healthcare Science	Female	1	1	12.50%
Executive Director of Organisational Development & Workforce	Female	1	1	12.50%
Director of Strategic Transformation, Planning & Digital	Male	1	1	12.50%
Director of Corporate Governance & Chief of Staff	Female	1	1	12.50%
Grand Total		**8**	**8**	**100%**
	Male	**3**		**37.50%**
	Female	**5**		**62.50%**

STAFF COMPOSITION BY STAFF GROUP

During 2022/2023 the average full time equivalent (FTE) number of operational staff permanently employed by the Trust was 3,718. The average number of employees is calculated as the full time equivalent number of employees in each week of the financial year divided by the number of weeks in the financial year. The table below provides a breakdown of the workforce by staff grouping and in addition to permanently employed staff, shows staff on inward Secondment, agency staff and other staff.

	Average FTE Number of Operational Employees						
	Permanently Employed	**Staff on Inward Secondment**	**Agency Staff**	**Specialist Trainee**	**Other Staff**	**2022/2023 Total**	**2021/2022 Total**
Administrative, Clerical and Board Members	2,029	12	18	0	62	**2,121**	**2,029**
Medical and Dental	84	1	0	30	6	**121**	**117**
Nursing and Midwifery Registered	208	0	0	0	5	**213**	**204**
Professional, Scientific and Technical Staff	77	0	1	0	0	**78**	**73**
Additional Clinical Services	232	0	1	0	10	**243**	**247**
Allied Health Professionals	140	0	7	0	0	**147**	**139**
Healthcare Scientists	157	0	1	0	7	**165**	**153**
Estates and Ancillary	524	0	36	0	65	**625**	**641**
Students	3	0	0	0	2	**5**	**3**
Total	**3,454**	**13**	**64**	**30**	**157**	**3,718**	**3,606**

SICKNESS ABSENCE DATA 2022/23

Report	2022/23	2021/22	Variance
Total Days Lost FTE (Long Term):	21279.7	22290.4	-1,011
Total Days Lost FTE (Short Term):	11019.6	8873.39	2,146
Total Days Lost:	**32299.2**	**31163.8**	**1135.47**
Average Staff Employed in the Period – FTE	1441.05	1404.72	36.33
Average Working Days Lost (FTE):	**6.17**	**5.29**	**0.88**
Total Staff Employed in Period: (HC)	1641	1610	31
Total Staff Employed in Period with No Sickness Absence (Headcount):	573	618	-45
Percentage Staff with No Sick Leave:	**34.92**	**38.39**	**-3.47**

The Workforce team work with Divisions to manage the wellbeing of staff and sickness absence. Monthly performance reports are developed for Divisions and Executive colleagues to monitor sickness and COVID sickness absence. Interventions to support mangers are aligned to reasons for sickness to ensure effective interventions that support staff. Regular sickness audits are undertaken and manager drop in session are available to support mangers in ensuring staff are encouraged back to work.

The Trust also offers and provides staff with free access to a diverse range of traditional medical, psychological and complementary therapy interventions, to assist them to proactively and reactively manage their health and wellbeing. This includes an Employee Assistance Programme (EAP), which family members can also access for free.

The top reason for sickness absence across the Trust continues to be psychological ill health. To provide staff with appropriate and additional support in an unprecedented year, the Trust has focused on interventions to support the psychological wellbeing of our staff. This has included drop in session with our wellbeing team as well as on site support from our EAP service. As part of our Health and Wellbeing plan we are training mental health first aid champions and run a number of staff networks to support staff.

STAFF POLICIES

All Trust policies and procedures are equality impact assessed against the nine protected characteristics, to ensure that they do not discriminate against people who apply to work in the Trust or are employed by the Trust. All Trust policies and procedures are available to access via the Trust Internet website.

SALARY AND PENSION DISCLOSURE TABLES (AUDITED) – SINGLE TOTAL FIGURE OF REMUNERATION

This Remuneration Report includes a single total figure of remuneration. The amount of pension benefits for the year which contributes to the single total figure is calculated based on guidance provided by the NHS Business Services Authority Pensions Agency.

The amount included in the table for pension benefit is based on the increase in accrued pension adjusted for inflation. This will generally take into account an additional year of service together with any changes in pensionable pay. This is not an amount which has been paid to an individual by the Trust during the year; it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a person's salary, whether or not they choose to make additional contributions to the pension scheme from their pay, and other valuation factors affecting the pension scheme as a whole.

The salary and pension disclosures reflect the senior managers' information. As indicated on pages 12-13 the senior management team consists of the Chief Executive, the Executive Directors, and the Independent Members (Non-Executive Directors), the Chief Operating Officer, and the Director of Corporate Governance / Board Secretary / Chief of Staff.

SALARY AND PENSION DISCLOSURE TABLES (AUDITED) – SINGLE TOTAL FIGURE OF REMUNERATION (CONTINUED)

	2022/2023					2021/2022				
Name and Title	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind (to the nearest £100)**	**Pension benefits (to the nearest £1,000)**	**Total (to the nearest £5,000)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind (to the nearest £100)**	**Pension benefits (to the nearest £1,000)**	**Total (to the nearest £5,000)**
Executive Directors and Senior Managers										
Steve Ham Chief Executive	150-155	0	0	12	160-165	145-150	0	0	45	190-195
Matthew Bunce Executive Director of Finance[1, 4]	115-120	0	0	35	150-155	55-60	0	0	79	135-140
Jacinta Abraham Executive Medical Director[2]	120-125	30-35	0	8	155-160	115-120	30-35	0	86	230-235
Catherine O'Brien Chief Operating Officer[3, 4]	125-130	0	4	12	135-140	120-125	0	0	63	180-185
Lauren Fear Director of Corporate Governance & Chief of Staff	90-95	0	0	23	115-120	90-95	0	0	22	110-115
Nicola Williams Executive Director of Nursing, AHP and Healthcare Scientists	115-120	0	0	9	120-125	110-115	0	0	53	165-170

	2022/2023					2021/2022				
Name and Title	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind (to the nearest £100)**	**Pension benefits (to the nearest £1,000)**	**Total (to the nearest £5,000)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind (to the nearest £100)**	**Pension benefits (to the nearest £1,000)**	**Total (to the nearest £5,000)**
Sarah Morley Executive Director of Organisational Development and Workforce	100-105	0	0	18	115-120	95-100	0	0	38	135-140
Carl James Executive Director of Strategic Transformation, Planning, and Digital[3, 4]	125-130	0	4	0	125-130	120-125	0	1	50	170-175

Notes:

1. M Bunce was appointed to the role of Executive Director of Finance on 27/09/2021. The annualised salary band for this role during 2021/2022 was £110-115k.
2. Other remuneration for J Abraham relates to clinical responsibilities.
3. Benefits in kind for C James and C O'Brien relate to the use of a Trust lease car and taxable mileagepayments.
4. Three officers received payments during the year for the sale of 2021/2022 annual leave. These include M Bunce £4.2k, C O'Brien £1.9k and C James £4.7k.
5. Pension related figures above have not been updated with any increase in salaries relating to 2022/2023, as increases to pay scales were agreed after the pension information relating to 2022/2023 had been provided by the NHS Pension Agency.

SALARY AND PENSION DISCLOSURE TABLES (AUDITED) – SINGLE TOTAL FIGURE OF REMUNERATION (CONTINUED)

Name and Title	2022/2023					2021/2022				
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (to the nearest £100)	Pension benefits (to the nearest £1,000)	Total (to the nearest £5,000)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (to the nearest £100)	Pension benefits (to the nearest £1,000)	Total (to the nearest £5,000)
Independent Members/Non-Executive Directors										
Donna Mead, Chair	40-45	0	0	0	40-45	40-45	0	0	0	40-45
Martin Veale, Independent Member	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Stephen Harries, Vice Chair	30-35	0	0	0	30-35	30-35	0	0	0	30-35
Gareth Jones, Independent Member	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Hilary Jones, Independent Member	5-10	0	0	0	5-10	5-10	0	0	0	5-10
Andrew Westwell, Independent Member	5-10	0	0	0	5-10	0-5	0	0	0	0-5
Vicky Morris, Independent Member	5-10	0	0	0	5-10	0-5	0	0	0	0-5

SALARY AND PENSION DISCLOSURE

CASH EQUIVALENT TRANSFER VALUES

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or an arrangement to secure pension benefits in another pension scheme or an arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

REAL INCREASE IN CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

SALARY AND PENSION DISCLOSURE TABLES (AUDITED) – BOARD MEMBER AND VERY SENIOR MANAGER PENSIONS

Name and Title	Accrued pension at pension age as at 31 March 2023 and related lump sum (bands of £5,000)	Real increase in pension and related lump sum at pension age (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2023	Cash Equivalent Transfer Value at 31 March 2022	Real increase in Cash Equivalent Transfer Value	Employer contribution to partnership pension account
	£000	£000	£000	£000	£000	£000
Steve Ham Chief Executive[1]	180-185	0-2.5	48	0	27	0
Matthew Bunce Executive Director of Finance	145-150	10-12.5	930	832	50	0
Jacinta Abraham Executive Medical Director	155-160	0-2.5	1,103	1,035	15	0
Catherine O'Brien Chief Operating Officer	25-30	0-2.5	461	419	12	0
Lauren Fear Director of Corporate Governance & Chief of Staff	5-10	0-2.5	52	35	4	0
Nicola Williams Executive Director Nursing, AHP and Healthcare Scientists	185-190	0-2.5	1,102	1,035	19	0

Name and Title	Accrued pension at pension age as at 31 March 2023 and related lump sum (bands of £5,000)	Real increase in pension and related lump sum at pension age (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2023	Cash Equivalent Transfer Value at 31 March 2022	Real increase in Cash Equivalent Transfer Value	Employer contribution to partnership pension account
	£000	£000	£000	£000	£000	£000
Sarah Morley Executive Director of Organisational Development and Workforce	100-105	0-2.5	694	638	23	0
Carl James Executive Director of Strategic Transformation, Planning & Digital	55-60	0-2.5	747	706	3	0

Notes:

1. S Ham is over the Normal Pension Age (NPA) in the existing scheme, therefore a CETV calculation is not applicable. The CETV relates to the 2015 Scheme only.

As Independent Members do not receive pensionable remuneration, there are no entries in respect of pensions for Independent Members.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures

REPORTING OF OTHER COMPENSATION SCHEMES – EXIT PACKAGES

During 2022/2023 exit packages were approved for 4 staff with a value of £83,029 (2 staff, value £101,773 2021/2022). £158,903 exit costs were paid in 2022/2023, the year of departure (£25,899 2021/2022). These packages were paid in accordance with recognised NHS terms and conditions of service/Trust Policy. None of the exit packages reported related to senior officers. There were 3 special payments agreed in 2022/2023 total £61,462 (2021/2022 nil).

REMUNERATION RELATIONSHIP

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Velindre University NHS Trust in the financial year 2022/2023 was £150,000 - £155,000 (2021/2022, £145,000 - £150,000). This was: 5.2 times (2021/2022, 5.6) the median remuneration of the workforce, which was £29,383 (2021/2022, £26,365); 6.2 times (2021/2022, 6.7) the 25th percentile remuneration of the workforce, which was £24,069 (2021/2022, £23,525); and 3.5 times (2021/2022, 3.7) the 75th percentile remuneration of the workforce, which was £43,635 (2021/2022, £42,284).

The percentage change from the previous financial year in the remuneration of the Chief Executive was 3.4% and 9.1% in respect of employees taken as a whole.

In 2022/2023, 11 (2021/2022, 8) employees received remuneration in excess of the highest paid Director.

Remuneration for all staff ranged from £21,100 to £236,100 (2021/2022, £18,600 to £227,500).

Total remuneration includes salary and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Overtime payments are included in the calculation of both elements of the relationship.

EXPENDITURE ON CONSULTANCY

During 2022/2023 the Trust spent £4.044m of its revenue funding on external consultancy fees (£1.588m related to the NHS Wales Shared Services Partnership); and £0.827m of its capital funding on external consultancy fees, including £0.773m related to the new hospital project (and £0.048m related to the NHS Wales Shared Services Partnership).

Examples include:

- Accountancy fees
- Legal fees
- Design fees
- Project management fees & support costs
- IT consultancy and advice
- Fees relating to building management, including surveyor & electrical costs.

TAX ASSURANCE FOR OFF-PAYROLL ENGAGEMENTS

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, departments must publish information on their highly paid and/or senior off-payroll engagements. The information, contained in the three tables below, includes all off-payroll engagements as at 31st March 2023 for those earning more than £245 per day for the core Trust and its hosted organisations.

Table 1: Highly paid off-payroll worker engagements as at 31st March 2023, earning £245 per day or greater:

Number of existing engagements as of 31st March 2023	12
Of which, the number that have existed:	
less than 1 year	8
for between 1 and 2 years	2
for between 2 and 3 years	1
for between 3 & 4 years	0
for 4 or more years	1

Within the total number of off-payroll engagements disclosed, no engagements related to staff seconded from other NHS Wales Organisations.

All the off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax, and where necessary, that assurance has been sought.

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31st March 2023, earning £245 per day or greater:

Number of temporary off-payroll workers engaged during the year ended 31st March 2023	11
Of which:	
Not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined in-scope of IR35	5
Subject to off-payroll legislation and determined as out-of-scope of IR35	6
Number of engagements reassessed for compliance or assurance purposes during the year	5
Of which, number of engagements that saw a change to IR35 status following review	0

Within the total number of new off-payroll engagements disclosed, no engagements related to staff seconded from other NHS Wales Organisations.

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2022 and 31st March 2023

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

Where the Trust undertakes activities that are not funded by the Welsh Government the Trust receives income to cover its costs. Further detail of income received is published in the Trust's annual accounts; within note 4 headed 'other operating revenue'.

The Trust confirms it has complied with cost allocation and the charging requirements set out in HM Treasury guidance during the year.

The Trust ensures public funds are used appropriately and to deliver the intended objectives. Expenditure this year was regular and compliant with the relevant legislation. Fees and charges for services provided by public sector organisations pass on the full cost of providing those services and are in accord with Welsh Government requirements.

The Trust hosts the Welsh Risk Pool (WRP) as part of NHS Wales Shared Services Partnership (NWSSP) and therefore its accounts include the estimates of remote contingent liabilities from Welsh Health Organisations for potential litigation claims that could arise in the future due to known incidents. In 2022/2023, the financial statements of the Trust are reporting total remote contingent liabilities of £102m.

AUDIT CERTIFICATE AND AUDITOR GENERAL FOR WALES REPORT

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion on financial statements

I certify that I have audited the financial statements of Velindre University NHS Trust and its group for the year ended 31st March 2023 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows and the Statement of Changes in Taxpayers' Equity and related notes, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Velindre University NHS Trust and its group as at 31st March 2023 and of its surplus for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the trust in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my

other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern
In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Velindre University NHS Trust is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information
The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters
In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and

- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report or the Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

I have not received all the information and explanations I require for my audit

- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records;
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and
    - assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Trust will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the audited entity's internal auditors and those charged with governance, including obtaining and reviewing supporting documentation relating to Velindre University NHS Trust's policies and procedures concerned with:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.

- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud;
- Obtaining an understanding of Velindre University NHS Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Velindre University NHS Trust; and
- Obtaining an understanding of related party relationships

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of Velindre University NHS Trust's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities
I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report
I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
31 July 2023

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Velindre University NHS Trust

Finance Report

2022-2023

Velindre University NHS Trust

Foreword

These accounts for the period ended 31 March 2023 have been prepared to comply with International Financial Reporting Standards (IFRS) adopted by the European Union, in accordance with HM Treasury's FReM by Velindre University NHS Trust under schedule 9 section 178 Para 3 (1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers, with the approval of the Treasury, directed.

These are Group accounts showing the accounts of the Trust including those organisations hosted by it (see 'Statutory background' below), and are consolidated with the Trust's Charitable Fund of which the Trust is the Corporate Trustee.

Statutory background

The Trust was established by Statutory Instrument on 1 December 1993 with an operational date of 1 April 1994. At that time the Trust was a single specialty Trust providing only Cancer Services. Over the last 29 years, the Trust has significantly evolved and expanded. The main function of the Trust is to provide all-Wales and regional clinical health services to the NHS and the people of Wales. The Trust consists of two clinical divisions: the Welsh Blood Service and Velindre Cancer Service.

In addition to the above services, the Trust is host to two organisations. At period ended 31 March 2023, these were:

- NHS Wales Shared Services Partnership (NWSSP) which was set up on 1 April 2011; following which the functions of a number of separate services were transferred into NWSSP. NWSSP became a hosted body within Velindre NHS Trust on 1 June 2012. During 2022-2023 one existing service, the Single Lead Employer Scheme, completed a phased rollout to all core and specialty medical trainees in NHS Wales.

- Health Technology Wales (HTW) which was established on 1 April 2016 and continued to receive grant funding from Welsh Government under the Efficiency through Technology Programme.

Performance Management and Financial Results

Under the National Health Service (Wales) Act 2006 the financial obligations of the NHS Trust are contained within Schedules 4 2(1) and 4 2(2). These duties were amended for Local Health Boards by the National Health Services Finance (Wales) Act 2014 and a Ministerial direction placed the same statutory duties on NHS Trusts through the Welsh Health Circular WHC/2016/054, which sets out the duty to break even over a three year period.

The NHS Finance (Wales) Act 2014 came into effect from 1 April 2014 and the first assessment of the 3 year rolling financial duty took place at the end of 2016-2017.

The second duty arises as a result of the Welsh Ministers' powers to set financial objectives for the Trust under paragraph 2(2) of Schedule 4 of the National Health Service (Wales) 2006 Act. The planning requirement, which by virtue of being set as a financial objective becomes a statutory financial duty, was previously set by the Welsh Ministers and has been retained by WHC/2016/054.

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2023

	Note	2022-23 £000	2021-22 £000	2022-23 £000	2021-22 £000
		NHS Trust		Consolidated	
Revenue from patient care activities	3	**540,496**	736,708	**540,496**	736,708
Other operating revenue	4	**417,245**	307,091	**420,683**	307,366
Operating expenses	5.1	**(967,845)**	(1,042,935)	**(968,677)**	(1,042,786)
Operating (deficit)/surplus		**(10,104)**	864	**(7,498)**	1,288
Investment revenue	6	**1,257**	23	**1,401**	137
Other gains and losses	7	**3**	3	**3**	3
Finance costs	8	**8,920**	(1,093)	**8,920**	(1,093)
Consolidated Total				**2,826**	335
Retained surplus/(deficit) (including donated assets received or issued)	2.1.1	**76**	(203)		
Other Comprehensive Income					
Items that will not be reclassified to net operating costs:					
Net gain/(loss) on revaluation of property, plant and equipment		**4,826**	3,074	**4,826**	3,074
Net gain / (loss) on revaluation of right of use assets		**0**		**0**	
Net gain/(loss) on revaluation of intangible assets		**0**	0	**0**	0
Movements in other reserves		**0**	9,833	**0**	9,833
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale		**0**	0	**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0	**(488)**	124
Impairments and reversals		**(1,010)**	0	**(1,010)**	0
Transfers between reserves		**0**	0	**0**	0
Reclassification adjustment on disposal of available for sale financial assets		**0**	0	**0**	0
Sub total		**3,816**	12,907	**3,328**	13,031
Items that may be reclassified subsequently to net operating costs					
Net gain/(loss) on revaluation of financial assets held for sale		**0**	0	**0**	0
Sub total		**0**	0	**0**	0
Total other comprehensive income for the year		**3,816**	**12,907**	**3,328**	**13,031**
Total comprehensive income for the year		3,892	12,704	6,154	13,366

The notes on pages 6 to 75 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2023

		Note	31 March 2023	31 March 2022	31 March 2023	31 March 2022
			NHS Trust		Consolidated	
			£000	£000	£000	£000
Non-current assets	Property, plant and equipment	13	**155,615**	143,136	**155,615**	143,136
	Right of Use Assets	13.3	**14,803**		**14,803**	
	Intangible assets	14	**11,194**	8,667	**11,194**	8,667
	Trade and other receivables	17.1	**1,107,047**	1,092,008	**1,107,047**	1,092,008
	Other financial assets	18	**0**	0	**5,572**	5,826
	Total non-current assets		**1,288,659**	1,243,811	**1,294,231**	1,249,637
Current assets	Inventories	16.1	**34,070**	65,207	**34,070**	65,207
	Trade and other receivables	17.1	**565,742**	498,478	**565,752**	497,397
	Other financial assets	18	**0**	0	**0**	0
	Cash and cash equivalents	19	**31,136**	30,404	**33,735**	33,116
			630,948	594,089	**633,557**	595,720
	Non-current assets held for sale	13.2	**0**	0	**0**	0
	Total current assets		**630,948**	594,089	**633,557**	595,720
Total assets			**1,919,607**	1,837,900	**1,927,788**	1,845,357
Current liabilities	Trade and other payables	20	**(226,254)**	(235,852)	**(224,778)**	(235,900)
	Borrowings	21	**(1,123)**	0	**(1,123)**	0
	Other financial liabilities	22	**0**	0	**0**	**0**
	Provisions	23	**(392,525)**	(341,123)	**(392,525)**	(341,123)
	Total current liabilities		**(619,902)**	(576,975)	**(618,426)**	(577,023)
Net current assets/(liabilities)			**11,046**	17,114	**15,131**	18,697
Total assets less current liabilities			**1,299,705**	1,260,925	**1,309,362**	1,268,334
Non-current liabilities	Trade and other payables	20	**(3,092)**	(7,336)	**(3,092)**	(7,336)
	Borrowings	21	**(2,421)**	0	**(2,421)**	0
	Other financial liabilities	22	**0**	0	**0**	**0**
	Provisions	23	**(1,108,919)**	(1,094,206)	**(1,108,919)**	(1,094,206)
	Total non-current liabilities		**(1,114,432)**	(1,101,542)	**(1,114,432)**	(1,101,542)
Total assets employed			**185,273**	159,383	**194,930**	166,792
Financed by Taxpayers' equity:						
	Public dividend capital		**131,461**	112,982	**131,461**	112,982
	Retained earnings		**19,104**	15,466	**19,104**	15,466
	Revaluation reserve		**34,708**	30,935	**34,708**	30,935
	Other reserves		**0**	0	**0**	0
	Funds Held on Trust Reserves				**9,657**	7,409
	Total taxpayers' equity		**185,273**	159,383	**194,930**	166,792

The financial statements were approved by the Board on 27 July 2023 and signed on behalf of the Board by:

Steve Ham, Chief Executive and Accountable Officer

Date: 27 July 2023

The notes on pages 6 to 75 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2022-23	Public Dividend Capital	Retained earnings	Revaluation reserve	Total	FHOT Reserves	Consolidated Total
	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2022-23						
Balance as at 31 March 2022	112,982	15,466	30,935	159,383	7,409	166,792
NHS Wales Transfer	0	0	0	0	0	0
RoU Asset Transitioning Adjustment	0	3,519	0	3,519	0	3,519
Balance at 1 April 2022	112,982	18,985	30,935	162,902	7,409	170,311
Retained surplus/(deficit) for the year		76		76		76
Net gain/(loss) on revaluation of property, plant and equipment		0	4,826	4,826		4,826
Net gain/(loss) on revaluation of right of use assets		0	0	0		0
Net gain/(loss) on revaluation of intangible assets		0	0	0		0
Net gain/(loss) on revaluation of financial assets		0	0	0	(488)	(488)
Net gain/(loss) on revaluation of assets held for sale		0	0	0		0
Net gain/(loss) on revaluation of financial assets held for sale		0	0	0		0
Impairments and reversals		0	(1,010)	(1,010)		(1,010)
Other reserve movement		0	0	0		0
Transfers between reserves		43	(43)	0		0
Reclassification adjustment on disposal of available for sale financial assets		0	0	0		0
Reserves eliminated on dissolution	0			0		0
Total in year movement	0	119	3,773	3,892	(488)	3,404
New Public Dividend Capital received	18,894			18,894		18,894
Public Dividend Capital repaid in year	(415)			(415)		(415)
Public Dividend Capital extinguished/written off	0			0		0
PDC Cash Due but not issued				0		0
Other movements in PDC in year	0			0		0
FHoT - Endowment					0	0
FHoT - Restricted					0	0
FHoT - Unrestricted					2,736	2,736
Balance at 31 March 2023	131,461	19,104	34,708	185,273	9,657	194,930

The notes on pages 6 to 75 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

2021-22	Public Dividend Capital	Retained earnings	Revaluation reserve	Total	Funds held on Trust Reserves	Consolidated Total
	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2021-22						
Balance at 31 March 2021	122,468	15,552	27,978	165,998	6,747	172,745
NHS Wales Transfer	(27,872)	(9,833)	0	(37,705)	0	(37,705)
RoU Asset Transitioning Adjustment						
Balance at 1 April 2021	94,596	5,719	27,978	128,293	6,747	135,040
Retained surplus/(deficit) for the year		(203)		(203)		(203)
Net gain/(loss) on revaluation of property, plant and equipment		0	3,074	3,074		3,074
Net gain/(loss) on revaluation of right of use assets						
Net gain/(loss) on revaluation of intangible assets		0	0	0		0
Net gain/(loss) on revaluation of financial assets		0	0	0	124	124
Net gain/(loss) on revaluation of assets held for sale		0	0	0		0
Net gain/(loss) on revaluation of financial assets held for sale		0	0	0		0
Impairments and reversals		0	0	0		0
Other reserve movement		9,833	0	9,833		9,833
Transfers between reserves		117	(117)	0		0
Reclassification adjustment on disposal of available for sale financial assets		0	0	0		0
Reserves eliminated on dissolution	0			0		0
Total in year movement	0	9,747	2,957	12,704	124	12,828
New Public Dividend Capital received	18,386			18,386		18,386
Public Dividend Capital repaid in year	0			0		0
Public Dividend Capital extinguished/written off	0			0		0
PDC Cash Due but not issued						
Other movements in PDC in year	0			0		0
FHoT - Endowment					0	0
FHoT - Restricted					0	0
FHoT - Unrestricted					538	538
Balance at 31 March 2022	112,982	15,466	30,935	159,383	7,409	166,792

The notes on pages 6 to 75 form part of these accounts.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2023

	Note	2022-23 £000	2021-22 £000	2022-23 £000	2021-22 £000
Cash flows from operating activities		**NHS Trust**		**Consolidated**	
Operating surplus/(deficit)	SOCI	**(10,104)**	864	**(7,498)**	1,288
Movements in working capital	30	**(56,728)**	(315,095)	**(59,216)**	(314,364)
Other cash flow adjustments	31	**199,189**	453,490	**199,189**	453,490
Provisions utilised		**(117,852)**	(143,680)	**(117,852)**	(143,680)
Interest paid		**(40)**	0	**(40)**	0
Net cash inflow (outflow) from operating activities		**14,465**	(4,421)	**14,583**	(3,266)
Cash flows from investing activities					
Interest received		989	23	**1,133**	137
(Payments) for property, plant and equipment		(28,993)	(22,771)	**(28,993)**	(22,771)
Proceeds from disposal of property, plant and equipment		3	11,931	**3**	11,931
(Payments) for intangible assets		(3,103)	(4,103)	**(3,103)**	(4,103)
Proceeds from disposal of intangible assets		0	15,976	**0**	15,976
Payments for investments with Welsh Government		0	0	**0**	0
Proceeds from disposals with Welsh Government		0	0	**0**	0
(Payments) for financial assets.		0	0	**(1,158)**	(2,005)
Proceeds from disposal of financial assets.		0	0	**783**	1,900
Net cash inflow (outflow) from investing activities		**(31,104)**	1,056	**(31,335)**	1,065
Net cash inflow (outflow) before financing		**(16,639)**	(3,365)	**(16,752)**	(2,201)
Cash flows from financing activities					
Public Dividend Capital received		**18,894**	0	**18,894**	0
Public Dividend Capital repaid		**(415)**	(9,486)	**(415)**	(9,486)
Loans received from Welsh Government		**0**	0	**0**	0
Loans repaid to Welsh Government		**0**	0	**0**	0
Other loans received		**0**	0	**0**	0
Other loans repaid		**0**	0	**0**	0
Other capital receipts		**0**	0	**0**	0
Capital elements of finance leases and on-SOFP PFI		**0**	(8)	**0**	(8)
Capital element of payments in respect of on-SoFP PFI		**0**	0	**0**	0
Capital Element of payments in respect of Right of Use Assets		**(1,108)**		**(1,108)**	
Cash transferred (to)/from other NHS Wales bodies		**0**	0	**0**	0
Net cash inflow (outflow) from financing activities		**17,371**	(9,494)	**17,371**	(9,494)
Net increase (decrease) in cash and cash equivalents		**732**	(12,859)	**619**	(11,695)
Cash [and] cash equivalents at the beginning of the financial year	19	**30,404**	43,263	**33,116**	44,811
Cash [and] cash equivalents at the end of the financial year	19	**31,136**	30,404	**33,735**	33,116

The notes on pages 6 to 75 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of NHS Trusts (NHST) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2022-2023 Manual for Accounts. The accounting policies contained in that manual follow the 2022-2023 Financial Reporting Manual (FReM), in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006 to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the NHST Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHST for the purpose of giving a true and fair view has been selected. The particular policies adopted by the NHST are described below. They have been applied consistently in dealing with items considered material in relation to the accounts*.*

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2 Acquisitions and discontinued operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.3 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

From 2018-2019, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FReM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income is received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred.

Only non-NHS income may be deferred.

1.4 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019-2020 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, and in Wales the additional 6.3% would be funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA, the NHS Pensions Agency).

However, NHS Wales organisations are required to account for **their staff** employer contributions of 20.68% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see Other note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;

● it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;

● it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single

managerial control; or

● items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1 April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Income (SoCI).

From 2015-2016, IFRS 13 Fair Value Measurement must be complied with in full. However IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any carrying value of the item replaced is written-out and charged to the SoCI. As highlighted in previous years the NHS in Wales does not have systems in place to ensure that all items being "replaced" can be identified and hence the cost involved to be quantified. The NHS in Wales has thus established a national protocol to ensure it complies with the standard as far as it is able to which is outlined in the capital accounting chapter of the Manual For Accounts. This ensures that asset carrying values are not materially overstated.

For All Wales Capital Schemes that are completed in a financial year, NHS Wales organisations are required to obtain a revaluation during that year (prior to them being brought into use) and also similar revaluations are needed for all Discretionary Building Schemes completed which have a spend greater than £0.5m. The write downs so identified are then charged to operating expenses.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

● the technical feasibility of completing the intangible asset so that it will be available for use

● the intention to complete the intangible asset and use it

● the ability to use the intangible asset

● how the intangible asset will generate probable future economic benefits

● the availability of adequate technical, financial and other resources to complete the intangible asset and use it

● the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCI. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCI. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings.

1.9 Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and benefits there from can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCI on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCI. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1 April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The Trust has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application the Trust has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application has been employed per paragraph C10 (c) of IFRS 16. Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16. There are further expedients or election that have been employed by the Trust in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The Trust will not apply IFRS 16 to any new leases of in tangible assets applying the treatment described in section 1.14 instead.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The Trust is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the Trust has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The Trust is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 The Trust as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The entity employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16, and any new leases up to 31st December 2022. The rate of 3.51% has been applied for those commencing on or after 1 January 2023.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the Trust applies a revised rate to the remaining lease liability.

Where existing leases are modified the Trust must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the Trust.

1.11.2 The Trust as lessor (where relevant)

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the Trust is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the Trust has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12 Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Where inventories are not subject to high turnover levels, stocks are valued at current purchase price as an approximation to net realisable value and fair value.
Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14 Provisions

Provisions are recognised when the NHS Wales organisation has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Wales organisation will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the NHS Wales organisation has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the NHS Wales organisation has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1 Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operate a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participating NHS Wales bodies. The risk sharing option was implemented in both 2022-23 and 2021-22. The WRPS is hosted by the Trust.

1.14.2 Future Liability Scheme (FLS)

General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GP services in Wales.

In March 2019, the Minister issued a Direction to Velindre University NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1 April 2019.

1.15 Financial Instruments

From 2018-2019 IFRS 9 Financial Instruments is applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales organisations is a change to the calculation basis for bad debt provisions: changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

1.16 Financial assets

Financial assets are recognised on the SoFP when the NHS Wales organisation becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses.

All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1 Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets ‘at fair value' through SoCI; ‘held to maturity investments’; ‘available for sale’ financial assets, and ‘loans and receivables’. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2 Financial assets at fair value through SoCI

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCI. They are held at fair value, with any resultant gain or loss recognised in the SoCI. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4 Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCI on de-recognition.

1.16.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the NHS Wales organisation assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the expenditure and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.16.6 Other financial assets

Listed investments are stated at market value. Unlisted investments are included at cost as an approximation to market value. Quoted stocks are included in the balance sheet at mid-market price, and where holdings are subject to bid / offer pricing their valuations are shown on a bid price. The shares are not held for trading and accordingly are classified as available for sale. Other financial assets are classified as available for sale investments carried at fair value within the financial statements.

1.17 Financial liabilities

Financial liabilities are recognised on the SOFP when the NHS Wales organisation becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired. Loans from Welsh Government are recognised at historical cost.

1.17.1 Financial liabilities are initially recognised at fair value through SoCI

Financial liabilities are classified as either financial liabilities at fair value through the SoCI or other financial liabilities.

1.17.2 Financial liabilities at fair value through the SoCI

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCI. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 Value Added Tax (VAT)

Most of the activities of the NHS Wales organisation are outside the scope of VAT and, in general, output VAT does not apply and input VAT on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCI. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21 Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCI on an accruals basis, including losses which would have been made good through insurance cover had the NHS Wales organisation not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The NHS Wales organisation accounts for all losses and special payments gross (including assistance from the WRPS).

The NHS Wales organisation accrues or provides for the best estimate of future payouts for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for, where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5-50%, the liability is disclosed as a contingent liability.

1.22 Pooled budget

The NHS Wales organisation has/has not entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

1.23 Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the WRPS.

1.25 Provisions for legal or constructive obligations for clinical negligence, personal injury & defence costs

The NHS Wales organisation provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the WRPS which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisations, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement:

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision*
		Contingent Liability for all other estimated expenditure
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of -0.25%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%-94% respectively are held as a provision on the Trust's balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

Discounting provisions
The WRPS discounts estimated future lump sums within the provisions which are assumed to settle over a 3 year period.

A proportion of the lump sum estimates are assumed to settle with RPI indexed annual payments and the remainder as Annual Survey of Hours and Earnings (ASHE) indexed annual payments.

The HM Treasury short term nominal discount rate of 3.27% (2021/2022: 0.47%) is applied to the RPI proportion of the lump sum estimate using the retail price index (RPI) inflation rates of 8.60% for Year 1, 1.8% for Year 2 and 3.20 for Year 3.

The RPI rates have been calculated by reference to CPI for general provisions, with a 1% margin added to CPI indices to the period to 31st January 2030 and 0.1% thereafter. These are the rates recommended by the Government's Actuary's Department in lieu of published RPI rates which were omitted from the December 2021 HMT Public Expenditure System (PES) paper. The remainder is discounted by applying the Annual Survey of Hours and Earnings (ASHE) nominal discount rate of 1.9% (1.9% 2022) with the underlying RPI rates for Years 1 – 3 as above.

PPO Provisions

The majority of high value (>£1M) claims settle with a Periodical Payment Order (PPO) where part or all of the final settlement value is paid over the life time of the claimant. When cases settle with a PPO arrangement, an individual provision is created by multiplying the claimants' index linked annual payment value by the number of years' life expectancy. Future cashflows are modelled based on individual claim data and include any agreed future steps in payment value.

The number of years' life expectancy is discounted according to the Ogden table multipliers using HM Treasury's nominal discount rate for general provisions issued annually in the Public Expenditure System (PES) paper and an inflation factor.

For 2022-2023, the nominal short, medium, long and very long term rates are: 3.27%, (0-5 years), 3.20%, (+5-10 years) 3.51%(+10-40 years) and 3.00% (over 40 years) respectively. The inflation factor applied is dependent upon the rate agreed as part of the settlement of the claimant's case.

Where annual payments are required to be uplifted by the RPI, the RPI rate of 8.60% has been used for Year 1, 1.80% for Year 2, 3.20% for the period up to and including 31st January 2030 and 2.10% thereafter.

Where annual payments are required to be uplifted based on market data for carers' wages, the annual survey of hours and earnings (ASHE) discount rate of -6.7% for Year 1 has been applied, 0.1% for Year 2, -1.3% for the period up to and including 31st January 2030 and -0.2% thereafter. The probabilities of survival for each claimant are based on estimated life expectancy, agreed by medical experts in each case.

1.26 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities will be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined will be included.

1.27 Private Finance Initiative (PFI) transactions

The Trust has no PFI arrangements.

1.28 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.29 Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting, dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

For transfers of functions involving NHS Wales Trusts in receipt of PDC the double entry for the fixed asset NBV value and the net movement in assets is PDC.

1.30 Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM:

IFRS14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.31 Accounting standards issued that have been adopted early

During 2022-2023 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.32 Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as it is the corporate trustee of the Velindre University NHS Trust Charitable Fund it is therefore considered for accounting standards compliance to have control of Velindre University NHS Trust Charitable Fund as a subsidiary, and with the agreement of Welsh Government has made the decision to consolidate the Velindre University NHS Trust Charitable Fund within the statutory accounts of the Trust.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Velindre University NHS Trust Charitable Fund or its independence in its management of charitable funds.

Welsh Government as the ultimate parent of the NHS Wales organisations will disclose the Charitable Accounts in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties notes.

1.33 Subsidiaries

Material entities over which the NHS Wales organisation has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Wales organisation or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.35 Public Dividend Capital (PDC) and PDC dividend

PDC represents taxpayers' equity in the NHS Wales organisation. At any time the Minister for Health and Social Services with the approval of HM Treasury can issue new PDC to, and require repayments of, PDC from the NHS wales organisation. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

From 1 April 2010 the requirement to pay a public dividend over to the Welsh Government ceased.

2. Financial Performance

2.1 STATUTORY FINANCIAL DUTIES

Under the National Health Services (Wales) Act 2006 the financial obligations of the NHS Trust are contained within Schedules 4 2(1) and 4(2).

The Trust is required to achieve financial breakeven over a rolling 3 year period.

Welsh Health Circular WHC/2016/054 replaced WHC/2015/014 'Statutory and Financial Duties of Local Health Boards and NHS Trusts' and further clarifies the statutory financial duties of NHS Wales bodies.

2.1.1 Financial Duty

	Annual financial performance			**2020-21 to 2022-23**
	2020-21 £000	2021-22 £000	2022-23 £000	**Financial duty £000**
Retained surplus / (deficit)	1,222	(203)	76	**1,095**
Less Donated asset / grant funded revenue adjustment	(1,184)	244	0	**(940)**
Adjusted surplus/ (Deficit)	38	41	76	**155**

The Trust has met its financial duty to break even over the 3 years 2020-2021 to 2022-2023.

2.1.2 Integrated Medium Term Plan (IMTP)

The NHS Wales Planning Framework for the period 2022-2025 issued to Trusts placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The Trust submitted an Integrated Medium Term Plan for the period 2022-2025 in accordance with NHS Wales Planning Framework.

Status	**Approved**
Date	13/07/2022

The Trust has therefore met its statutory duty to have an approved financial plan.

2. Financial Performance (cont)

2.2 ADMINISTRATIVE REQUIREMENTS

2.2.1. External financing

The EFL target has been suspended in 2022-23.

2.3. Creditor payment

The Trust is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The Trust has achieved the following results:

	2022-23	2021-22
Total number of non-NHS bills paid	**81,328**	72,627
Total number of non-NHS bills paid within target	**77,780**	69,488
Percentage of non-NHS bills paid within target	**95.6%**	95.7%

The Trust has met the target.

3. Revenue from patient care activities	2022-23	2021-22	2022-23	2021-22
	NHS Trust		Consolidated	
	£000	£000	£000	£000
Local health boards	95,698	88,569	95,698	88,569
Welsh Health Specialised & Emergency Ambulance Services Committees (WHSSC & EASC)	52,959	49,172	52,959	49,172
Welsh NHS Trusts	1,494	1,512	1,494	1,512
Welsh Special Health Authorities	2,159	1,465	2,159	1,465
Foundation Trusts	0	0	0	0
Other NHS England bodies	107	107	107	107
Other NHS Bodies	9	1	9	1
Local Authorities	0	0	0	0
Welsh Government	16,250	13,533	16,250	13,533
Welsh Government Welsh Risk Pool Reimbursements			0	
NHS Wales Secondary Health Sector	199,763	424,563	199,763	424,563
NHS Wales Primary Sector Future Liability Scheme Reimbursement	144	93	144	93
NHS Wales Redress	1,503	1,679	1,503	1,679
Other	0	0	0	0
Welsh Government - Hosted Bodies	168,350	153,833	168,350	153,833
Non NHS:				
Private patient income	2,032	2,017	2,032	2,017
Overseas patients (non-reciprocal)	0	0	0	0
Injury Costs Recovery (ICR) Scheme	0	0	0	0
Other revenue from activities	28	164	28	164
Total	540,496	736,708	540,496	736,708

Injury Cost Recovery (ICR) Scheme income:

	2022-23	2021-22
	%	%
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	23.76	23.76

4. Other operating revenue	2022-23	2021-22	2022-23	2021-22
	£000	£000	£000	£000
	NHS Trust		Consolidated	
Income generation	549	842	549	842
Patient transport services	0	0	0	0
Education, training and research	3,877	5,431	3,877	5,431
Charitable and other contributions to expenditure	1,858	3,105	515	314
Incoming FHoT Revenue				
Unrestricted - donations and legacies			4,781	3,066
Restricted - donations and legacies			0	0
Receipt of Covid Items free of charge from other NHS Wales Organisations	0	0	0	0
Receipt of Covid Items free of charge from other organisations	0	0	0	0
Receipt of donations for capital acquisitions	0	0	0	0
Receipt of government grants for capital acquisitions	0	0	0	0
Right of Use Grant (Peppercorn Lease)	0		0	
Non-patient care services to other bodies	931	936	931	936
Right of Use Asset Sub-leasing rental income	0		0	
Rental revenue from finance leases	10	0	10	0
Rental revenue from operating leases	100	133	100	133
Other revenue:				
Provision of pathology/microbiology services	0	0	0	0
Accommodation and catering charges	211	180	211	180
Mortuary fees	0	0	0	0
Staff payments for use of cars	157	103	157	103
Business unit	0	0	0	0
Scheme Pays Reimbursement Notional	(169)	339	(169)	339
Other	409,721	296,022	409,721	296,022
Total	417,245	307,091	420,683	307,366
Total Patient Care and Operating Revenue	957,741	1,043,799	961,179	1,044,074

Other revenue comprises:

NHS Wales Shared Services Partnership	406,288	291,705	406,288	291,705
Other	3,433	4,317	3,433	4,317
Total	409,721	296,022	409,721	296,022

On 1st April 2019 employer pension contributions increased by 6.3%. Welsh Government funded this by making payment directly to the NHS Business Services Agency on the Trust's behalf. The notional income of £14.659m (2021/2022 £11.406m) is reported within the above notes, with further details provided in note 37.1.

5. Operating expenses	2022-23	2021-22	2022-23	2021-22
5.1 Operating expenses	£000	£000	£000	£000
	NHS Trust		Consolidated	
Local Health Boards	**14,484**	11,464	**14,484**	11,464
Welsh NHS Trusts	**18**	23	**18**	23
Welsh Special Health Authorities	**2,021**	1,170	**2,021**	1,170
Goods and services from other non Welsh NHS bodies	**0**	0	**0**	0
WHSSC/EASC	**0**	0	**0**	0
Local Authorities	**3**	0	**3**	0
Purchase of healthcare from non-NHS bodies	**0**	0	**0**	0
Welsh Government	**0**	0	**0**	0
Other NHS Trusts	**508**	514	**508**	514
Directors' costs	**1,420**	1,392	**1,420**	1,392
Operational Staff costs	**171,346**	153,982	**171,346**	153,982
Non operational trainee staff costs	**229,121**	137,379	**229,121**	137,379
Non operational collaborative bank staff costs	**347**	234	**347**	234
Single lead employer Staff Trainee Cost	**2,743**	1,033	**2,743**	1,033
Collaborative Bank Staff Cost	**0**	0	**0**	0
Supplies and services - clinical	**144,992**	136,174	**144,992**	136,174
Supplies and services - general	**83,340**	78,047	**83,340**	78,047
Consultancy Services	**3,950**	4,224	**3,950**	4,224
Establishment	**13,206**	12,383	**13,206**	12,383
Transport	**3,483**	3,160	**3,483**	3,160
Premises	**29,863**	24,771	**29,863**	24,771
FHoT Resources expended				
Costs of generating funds			**654**	157
Charitable activites			**178**	(306)
Governance Costs			**(17)**	(15)
Impairments and Reversals of Receivables	**0**	0	**0**	0
Depreciation	**8,826**	9,110	**8,826**	9,110
Depreciation (RoU Asset)	**1,676**		**1,676**	
Amortisation	**1,358**	1,112	**1,358**	1,112
Impairments and reversals of property, plant and equipment	**1,121**	0	**1,121**	0
Fixed asset impairments and reversals (RoU Assets)	**1,894**		**1,894**	
Impairments and reversals of intangible assets	**348**	0	**348**	0
Impairments and reversals of financial assets	**0**	0	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0	**0**	0
Audit fees	**243**	224	**260**	239
Other auditors' remuneration	**0**	0	**0**	0
Losses, special payments and irrecoverable debts	**227,983**	447,889	**227,983**	447,889
Research and development	**0**	0	**0**	0
NWSSP centrally purchased and donated Covid assets issued free of charge to NHS Wales organisations	**0**	0	**0**	0
NWSSP centrally purchased Covid assets issued free of charge to other organisations	**0**	0	**0**	0
Expense related to short-term leases	**369**		**369**	
Expense related to low-value asset leases (excluding short-term leases)	**60**		**60**	
Other operating expenses	**23,122**	18,650	**23,122**	18,650
Total	**967,845**	1,042,935	**968,677**	1,042,786

On 1st April 2019 employer pension contributions increased by 6.3%. Welsh Government funded this by making payment directly to the NHS Pensions Agency on the Trust's behalf. The notional expenditure of £14.659m (£11.406m 2021/2022) is reported above under the various staff cost headings. Further detail is provided in note 37.1.

Staff costs are split over a number of different headings. Operational staff costs are those staff employed by the Trust and deemed operational within it. Non-operational trainee staff costs are those trainees employed by NWSSP under the All Wales Single Lead Employer Scheme (SLE) on behalf of other NHS Wales organisations, and who are operational within those organisations rather than the Trust. Where NWSSP employ staff under the SLE scheme on behalf of the Trust, these costs are reported as Single Lead Employer Staff Trainee costs. Staff employed under another NWSSP scheme, which commenced in 2020/2021, the All Wales Collaborative Bank, are also identified separately and split between those operational within the Trust and those operational in other NHS Wales organisations. Further analysis of these costs is shown in notes 10.1 and 10.7, with details of average numbers of employees shown in notes 10.2 and 10.8.

Following WG guidance £39,947,860 relating to pharnacy rebates with the other Heath Boards has been restated last year from supplies services - general to supplies and services - clinical to ensure consistency with this years treatment.

5. Operating expenses (continued)
5.2 Losses, special payments and irrecoverable debts:

Charges to operating expenses **Increase/(decrease) in provision for future payments:**	**2022-23** **£000**	2021-22 £000	**2022-23** **£000**	2021-22 £000
	NHS Trust		**Consolidated**	
Clinical negligence;-				
Secondary care	**212,515**	299,158	**212,515**	299,158
Primary care	**567**	92	**567**	92
Redress Secondary Care	**2,365**	951	**2,365**	951
Redress Primary Care	**0**	0	**0**	0
Personal injury	**2,127**	(1,777)	**2,127**	(1,777)
All other losses and special payments	**16,839**	23,441	**16,839**	23,441
Defence legal fees and other administrative costs	**2,744**	2,057	**2,744**	2,057
Structured Settlements Welsh Risk Pool	**(9,174)**	123,967	**(9,174)**	123,967
Gross increase/(decrease) in provision for future payments	**227,983**	447,889	**227,983**	447,889
Contribution to Welsh Risk Pool	**0**	0	**0**	0
Premium for other insurance arrangements	**0**	0	**0**	0
Irrecoverable debts	**0**	0	**0**	0
Less: income received/ due from Welsh Risk Pool	**0**	0	**0**	0
Total charge	**227,983**	447,889	**227,983**	447,889

The Clinical Negligence figure includes £2,149,439 (2021/2022 £1,908,747) in respect of payments made under Redress during 2022/2023. The Redress creditor reduced by £646,000 in 2022/23 compared to a reduction in the creditor movement of £229,000 in 2021/22.

Other losses include stock revaluations of £12.9m and stock losses of £3.6m.

	2022-23 **£**	2021-22 £
Permanent injury included within personal injury:	**0**	0

6. Investment revenue	2022-23	2021-22	2022-23	2021-22
Rental revenue :	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
PFI finance lease revenue:				
Planned	**0**	0	**0**	0
Contingent	**0**	0	**0**	0
Other finance lease revenue	**0**	0	**0**	0
Interest revenue:				
Bank accounts	**1,257**	23	**1,257**	23
Other loans and receivables	**0**	0	**0**	0
Impaired financial assets	**0**	0	**0**	0
Other financial assets	**0**	0	**144**	114
Total	**1,257**	23	**1,401**	137

Interest received in 2022/2023 relates to the Trust's main bank account and an Escrow account established in relation to the build of the new cancer centre.

On 19th March 2020, the interest rate on the Trust's bank accounts was reduced to nil and remained at that rate until 16th December 2021. Interest received in 2021/2022 therefore related to the period 16th December 2021 to 31st March 2022. During 2022/2023 the interest rate remained above nil and therefore interest was received each month at the appropriate rate.

7. Other gains and losses	2022-23	2021-22	2022-23	2021-22
	£000	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Gain/(loss) on disposal of property, plant and equipment	**3**	3	**3**	3
Gain/(loss) on disposal of intangible assets	**0**	0	**0**	0
Gain/(loss) on disposal of assets held for sale	**0**	0	**0**	0
Gain/(loss) on disposal of financial assets	**0**	0	**0**	0
Gains/(loss) on foreign exchange	**0**	0	**0**	0
Change in fair value of financial assets at fair value through income statement	**0**	0	**0**	0
Change in fair value of financial liabilities at fair value through income statement	**0**	0	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0	**0**	0
Total	**3**	3	**3**	3

8. Finance costs	2022-23	2021-22	2022-23	2021-22
	£000	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Interest on loans and overdrafts	**0**	0	**0**	0
Interest on obligations under finance leases	**0**	0	**0**	0
Interest on obligations under Right of Use Leases	**40**		**40**	
Interest on obligations under PFI contracts:				
Main finance cost	**0**	0	**0**	0
Contingent finance cost	**0**	0	**0**	0
Interest on late payment of commercial debt	**0**	0	**0**	0
Other interest expense	**0**	0	**0**	0
Total interest expense	**40**	0	**40**	0
Provisions unwinding of discount	**(4,637)**	(50)	**(4,637)**	(50)
Periodical Payment Order unwinding of discount	**(4,323)**	1,143	**(4,323)**	1,143
Other finance costs	**0**	0	**0**	0
Total	**(8,920)**	**1,093**	**(8,920)**	**1,093**

9. Future change to SoCI/Operating Leases

9.1 Trust as lessee

Operating lease payments represent rentals payable by the Trust for properties and equipment.

	Post Implementation of IFRS 16		Pre implementation of IFRS 16	Post Implementation of IFRS 16		Pre implementation of IFRS 16
	Low Value & Short Term	Other		Low Value & Short Term	Other	
Payments recognised as an expense	**2022-23**	**2022-23**	2021-22	**2022-23**	**2022-23**	2021-22
	£000	**£000**	£000	**£000**	**£000**	£000
		NHS Trust			**Consolidated**	
Minimum lease payments	**429**	**0**	2,276	**429**	**0**	2,276
Contingent rents	**0**	**0**	0	**0**	**0**	0
Sub-lease payments	**0**	**0**	0	**0**	**0**	0
Total	**429**	**0**	2,276	**429**	**0**	2,276

Total future minimum lease payments	**2022-23**	**2022-23**	2021-22	**2022-23**	**2022-23**	2021-22
Payable:	**£000**	**£000**	£000	**£000**	**£000**	£000
		NHS Trust			**Consolidated**	
Not later than one year	**79**	**0**	1,762	**79**	**0**	1,762
Between one and five years	**101**	**0**	2,843	**101**	**0**	2,843
After 5 years	**0**	**0**	570	**0**	**0**	570
Total	**180**	**0**	5,175	**180**	**0**	5,175
Total future sublease payments expected to be received	**0**	**0**	0	**0**	**0**	0

As a result of the implementation of IFRS 16 the current year operating lease figures relate to low value and short term leases only. Previously reported expenditure of £nil and minimum lease payments of £4.8m transitioned to the balance sheet as right of use assets.

9. Future change to SoCI/Operating Leases (continued)

9.2 Trust as lessor

NWSSP continues to lease two areas of Matrix House to commercial entities. It also continues to lease areas of Matrix House to the Welsh Ambulance Services NHS Trust and Public Health Wales NHS Trust for zero consideration.

NWSSP also continues to lease a laboratory area of the IP5 warehouse to Public Health Wales for zero consideration. It also leased an area of the IP5 warehouse to DHSC for the Lighthouse Laboratory, but this arrangement ended during 2022/23.

Velindre Cancer Centre has an ongoing agreement with Cancer Research Wales to lease space in the research block building of Velindre Cancer Centre. Rental income is also received in respect of the staff residence in Whitchurch, Cardiff.

Rental Revenue

	Post Implementation of IFRS 16	Pre implementation of IFRS 16	**Post Implementation of IFRS 16**	Pre implementation of IFRS 16
Receipts recognised as income	**2022-23**	2021-22	**2022-23**	2021-22
	£000	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Rent	**100**	133	**100**	133
Contingent rent	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total rental revenue	**100**	133	**100**	133

Total future minimum lease payments Receivable:	**2022-23**	2021-22	**2022-23**	2021-22
	£000	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Not later than one year	**71**	266	**71**	266
Between one and five years	**97**	691	**97**	691
After 5 years	**0**	414	**0**	414
Total	**168**	1,371	**168**	1,371

10. Employee costs and numbers

10.1 Employee costs Operational Staff	Permanently employed staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2022-23 £000	2021-22 £000
	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	**129,105**	**754**	**2,273**	**2,208**	**5,188**	**139,528**	121,600
Social security costs	**12,939**	**0**	**0**	**269**	**223**	**13,431**	12,901
Employer contributions to NHS Pensions Scheme	**23,425**	**0**	**0**	**266**	**343**	**24,034**	23,247
Other pension costs	**48**	**0**	**0**	**0**	**0**	**48**	42
Other post-employment benefits	**0**	**0**	**0**	**0**	**7**	**7**	5
Termination benefits	**83**	**0**	**0**	**0**	**0**	**83**	102
Total	**165,600**	**754**	**2,273**	**2,743**	**5,761**	**177,131**	157,897

Of the total above:		
Charged to capital	**2,231**	1,633
Charged to revenue	**174,900**	156,264
Total	**177,131**	157,897

Net movement in accrued employee benefits (untaken staff leave)	**(25)**	35
Covid 19 - Net movement in accrued employee benefits (untaken staff leave)		538
Non Covid 19 - Net movement in accrued employee benefits (untaken staff leave)		(503)

The majority of staff reported as "other" are individuals working under NWSSP bank arrangements.

10.2 Average number of employees	Permanently Employed	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2022-23 Total	2021-22 Total
	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	**2,029**	**12**	**18**	**0**	**62**	**2,121**	2,029
Medical and dental	**84**	**1**	**0**	**30**	**6**	**121**	117
Nursing, midwifery registered	**208**	**0**	**0**	**0**	**5**	**213**	204
Professional, scientific and technical staff	**77**	**0**	**1**	**0**	**0**	**78**	73
Additional Clinical Services	**232**	**0**	**1**	**0**	**10**	**243**	247
Allied Health Professions	**140**	**0**	**7**	**0**	**0**	**147**	139
Healthcare scientists	**157**	**0**	**1**	**0**	**7**	**165**	153
Estates and Ancillary	**524**	**0**	**36**	**0**	**65**	**625**	641
Students	**3**	**0**	**0**	**0**	**2**	**5**	3
Total	**3,454**	**13**	**64**	**30**	**157**	**3,718**	3,606

The average number is calculated using the full time equivalent (FTE) of employees.

10.3. Retirements due to ill-health	2022-23	2021-22
Number		
Estimated additional pension costs £		

Please see note 10.9 for information relating to both operational and non operational staff. The information is supplied by the NHS Pensions Agency and is not split at source.

10.4 Employee benefits

The Trust operates four salary sacrifice schemes (childcare vouchers, cycle to work, home electronics and lease cars) for the financial benefit of its employees. In addition, staff have access to a non contributory Employee Assistance Programme which provides financial wellbeing support; a financial wellbeing scheme to provide staff with access to simple financial education; salary deducted loans, and a range of savings and investment products. In 2022-2023 the Trust launched a health cash plan where staff can claim money back on everyday healthcare costs. It also provided a summer childcare subsidy scheme in 2022-2023 and a purchase of annual leave scheme.

10.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2022-23 Number of compulsory redundancies Whole numbers only	2022-23 Number of other departures Whole numbers only	2022-23 Total number of exit packages Whole numbers only	2022-23 Number of departures where special payments have been made Whole numbers only	2021-22 Total number of exit packages Whole numbers only
less than £10,000	0	1	**1**	1	0
£10,000 to £25,000	1	0	**1**	0	0
£25,000 to £50,000	0	2	**2**	2	1
£50,000 to £100,000	0	0	**0**	0	1
£100,000 to £150,000	0	0	**0**	0	0
£150,000 to £200,000	0	0	**0**	0	0
more than £200,000	0	0	**0**	0	0
Total	**1**	**3**	**4**	**3**	**2**

Exit packages cost band (including any special payment element)	2022-23 Cost of compulsory redundancies £	2022-23 Cost of other departures £	2022-23 Total cost of exit packages £	2022-23 Cost of special element included in exit packages £	2021-22 Total cost of exit packages £
less than £10,000	0	3,178	**3,178**	3,178	0
£10,000 to £25,000	21,567	0	**21,567**	0	0
£25,000 to £50,000	0	58,284	**58,284**	58,284	25,899
£50,000 to £100,000	0	0	**0**	0	75,874
£100,000 to £150,000	0	0	**0**	0	0
£150,000 to £200,000	0	0	**0**	0	0
more than £200,000	0	0	**0**	0	0
Total	**21,567**	**61,462**	**83,029**	**61,462**	**101,773**

Exit costs paid in year of departure	Total paid in year 2022-23 £	Total paid in year 2021-22 £
Exit costs paid in year	**158,903**	25,899
Total	**158,903**	**25,899**

Redundancy and other departure costs have been paid in accordance with the provisions of the relevant schemes or legislation. Where the Trust has agreed early retirements or compulsory redundancies, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table (see notes 10.3 & 10.9 for details of ill health retirement costs).

The disclosure reports the number and value of exit packages agreed in the year in line with the Welsh Government manual for accounts. The values payable to the individuals are shown. Any on costs are excluded as they do not form part of the payment to the individual.

There were 3 special payments agreed in 2022/2023 (2021/2022 nil).

The maximum payment made during 2022/23 was £30,081, the lowest payment made during 2022/23 was £3,178, with the median payment being £24,885

10.6 Fair Pay disclosures

10.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

	2022-23	**2022-23**	**2022-23**	2021-22	2021-22	2021-22
	£000	**£000**		£000	£000	
Total pay and benefits	**Chief Executive**	**Employee**	**Ratio**	Chief Executive	Employee	Ratio
25th percentile pay ratio	**152.0**	**24.0**	**6.3**	147.5	22.0	6.7
Median pay	**152.0**	**29.0**	**5.2**	147.5	26.4	5.6
75th percentile pay ratio	**152.0**	**44.0**	**3.5**	147.5	40.3	3.7
Salary component of total pay and benefits						
25th percentile pay ratio	**152.0**	**24.0**		147.5	21.8	
Median pay	**152.0**	**27.0**		147.5	24.9	
75th percentile pay ratio	**152.0**	**42.0**		147.5	40.1	

In 2022-23, 11 (2021-2022, 8) employees received remuneration in excess of the highest-paid Chief Executive.

Remuneration for all staff ranged from £21,100 to £236,100 (2021-2022, £18,600 to £227,500).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees. As the Highest Paid Director has no control over the performance of the Trust, the information in the lower half of the table has not been included.

Financial year summary

The current financial year's pay ratios are not dissimilar to the previous year. The decrease in the median pay ratio is generally attributable to an increase in the banding of the remuneration of the Chief Executive.

10.6.2 Percentage Changes	**2021-22 to 2022-23**	2020-21 to 2021-22
% Change from previous financial year in respect of Chief Executive	**%**	%
Salary and allowances	**3.4**	3.5
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances		
Performance pay and bonuses		
Average % Change from previous financial year in respect of employees taken as a whole		
Salary and allowances	**9.1**	-5.6
Performance pay and bonuses	**0**	0

The average % change from the previous financial year in respect of employees taken as a whole has increased primarily due to an increase in the sum of allowances paid.

The employees of the Trust do not receive any performance pay or bonuses.

10.7 Operational and Non Operational Employee costs

	Operational Staff Total	Non operational staff SLE Trainee Staff	Collaborative Bank Staff	Total 2022-23	2021-22
	£000	£000	£000	**£000**	£000
Salaries and wages	139,528	183,298	298	**323,124**	231,027
Social security costs	13,431	22,249	19	**35,699**	25,622
Employer contributions to NHS Pension Scheme	24,034	24,054	30	**48,118**	38,712
Other pension costs	48	0	0	**48**	42
Other employment benefits	7	0	0	**7**	5
Termination benefits	83	0	0	**83**	102
Total	177,131	229,601	347	**407,079**	295,510
Charged to capital	2,231	0	0	**2,231**	1,633
Charged to revenue	174,900	229,601	347	**404,848**	293,877
	177,131	229,601	347	**407,079**	**295,510**
Net movement in accrued employee benefits (untaken staff leave)	**(25)**	**0**	**0**	**(25)**	35
Covid 19 - Net movement in accrued employee benefits (untaken staff leave)					538
Non Covid 19 - Net movement in accrued employee benefits (untaken staff leave)					(503)

10.8 Average number of operational and non operational employees

	Operational Staff Total Number	Non operational staff SLE Trainee Staff Number	Collaborative Bank Staff Number	Total 2022-23 Number	2021-22 Number
Administrative, clerical and board members	2,121	0	0	**2,121**	2,029
Medical and dental	121	2,979	0	**3,100**	2,131
Nursing, midwifery registered	213	0	6	**219**	209
Professional, Scientific, and technical staff	78	0	0	**78**	73
Additional Clinical Services	243	113	0	**356**	368
Allied Health Professions	147	0	0	**147**	139
Healthcare Scientists	165	0	0	**165**	153
Estates and Ancillary	625	0	0	**625**	641
Students	5	0	0	**5**	3
Total	**3,718**	3,092	6	**6,816**	**5,746**

10.9. Retirements due to ill-health

	2022-23	2021-22
Number	3	5
Estimated additional pension costs £	189,690	310,700

Information received from the NHS Pensions Agency does not provide detail on whether the retirements related to operational or non operational staff.

10.10 Employee benefits

The Single Lead Employer Trainees are entitled to the same employee benefits as the Velindre operational staff.

10.11 Reporting of other compensation schemes - exit packages

There have been no exit package payments for the Single Lead Employer Trainee staff, therefore the figures reported in Note 10.5 remain unchanged.

11. Pensions

PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2022-2023 tax year (2021-2022 £6,240 and £50,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

12. Public Sector Payment Policy

12.1 Prompt payment code - measure of compliance

The Welsh Government requires that trusts pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the trust financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery or receipt of a valid invoice, whichever is the later.

	2022-23 Number	**2022-23 £000**	2021-22 Number	2021-22 £000
NHS				
Total bills paid in year	**2,622**	**109,896**	2,635	90,939
Total bills paid within target	**2,272**	**104,135**	2,388	81,381
Percentage of bills paid within target	**86.7%**	**94.8%**	90.6%	89.5%
Non-NHS				
Total bills paid in year	**81,328**	**365,417**	72,627	279,961
Total bills paid within target	**77,780**	**343,678**	69,488	270,196
Percentage of bills paid within target	**95.6%**	**94.1%**	95.7%	96.5%
Total				
Total bills paid in year	**83,950**	**475,313**	75,262	370,900
Total bills paid within target	**80,052**	**447,813**	71,876	351,577
Percentage of bills paid within target	**95.4%**	**94.2%**	95.5%	94.8%

12.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2022-23 £	2021-22 £
Amounts included within finance costs from claims made under legislation	**0**	0
Compensation paid to cover debt recovery costs under legislation	**0**	0
Total	**0**	0

13. Property, plant and equipment :

2022-23	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport Equipment	Information Technology	Furniture and fittings	Total	FHoT	Consolidated Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost at 31 March bf	17,756	84,488	283	29,664	43,408	7,910	21,208	1,866	206,583	0	206,583
NHS Wales Transfers	0	0	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset N	0	(12,133)	0	0	0	0	0	0	(12,133)	0	(12,133)
At 1 April 2022	17,756	72,355	283	29,664	43,408	7,910	21,208	1,866	194,450	0	194,450
Indexation	(327)	3,696	12	0	0	0	0	0	3,381	0	3,381
Additions - purchased	0	3,056	0	17,823	4,983	686	1,915	293	28,756	0	28,756
Additions - donated	0	0	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0	0	0
Reclassifications	1,400	(1,400)	0	0	113	0	0	0	113	0	113
Revaluation	2,629	(10,314)	(23)	0	0	0	0	0	(7,708)	0	(7,708)
Reversal of impairments	0	0	0	0	0	0	0	0	0	0	0
Impairments	0	(1,121)	0	0	0	0	0	0	(1,121)	0	(1,121)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,729)	(92)	(1,685)	0	(3,506)	0	(3,506)
At 31 March 2023	21,458	66,272	272	47,487	46,775	8,504	21,438	2,159	214,365	0	214,365
Depreciation											
Depreciation at 31 March bf	0	14,970	46	0	28,863	3,960	14,542	1,066	63,447	0	63,447
NHS Wales Transfers	0	0	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset N	0	(910)	0	0	0	0	0	0	(910)	0	(910)
At 1 April 2022	0	14,060	46	0	28,863	3,960	14,542	1,066	62,537	0	62,537
Indexation	0	508	0	0	0	0	0	0	508	0	508
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	45	0	0	0	45	0	45
Revaluation	0	(9,615)	(46)	0	0	0	0	0	(9,661)	0	(9,661)
Reversal of impairments	0	0	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,729)	(92)	(1,684)	0	(3,505)	0	(3,505)
Charged during the year	0	2,829	10	0	2,951	895	1,994	147	8,826	0	8,826
At 31 March 2023	0	7,782	10	0	30,130	4,763	14,852	1,213	58,750	0	58,750
Net book value											
At 1 April 2022	17,756	58,295	237	29,664	14,545	3,950	6,666	800	131,913	0	131,913
Net book value											
At 31 March 2023	21,458	58,490	262	47,487	16,645	3,741	6,586	946	155,615	0	155,615
Net book value at 31 March 2023 comprises :											
Purchased	21,458	53,473	262	47,487	16,615	3,741	6,583	946	150,565	0	150,565
Donated	0	5,017	0	0	30	0	3	0	5,050	0	5,050
Government Granted	0	0	0	0	0	0	0	0	0	0	0
At 31 March 2023	21,458	58,490	262	47,487	16,645	3,741	6,586	946	155,615	0	155,615
Asset Financing:											
Owned	21,458	58,490	262	47,487	16,645	3,741	6,586	946	155,615	0	155,615
Held on finance lease	0	0	0	0	0	0	0	0	0	0	0
On-SoFP PFI contract	0	0	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0	0	0
At 31 March 2023	21,458	58,490	262	47,487	16,645	3,741	6,586	946	155,615	0	155,615

The net book value of land, buildings and dwellings at 31 March 2023 comprises :

	£000	£000	£000
Freehold	67,948	0	67,948
Long Leasehold	12,165	0	12,165
Short Leasehold	0	0	0
Total	80,113	0	80,113

Valuers 'material uncertainty', in valuation.	0	0	**0**

The disclosure relates to the materiality in the valuation report not that of the underlying account.

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. Trusts are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

13. Property, plant and equipment :

2021-22	Land	Buildings, excluding dwellings	Dwellings	Assets under construttion and payments on account	Plant & machinery	Transport Equipment	Information Technology	Furniture and fittings	Total	FHoT	Consolidated Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost at 31 March bf	17,463	72,876	270	23,315	36,743	6,409	42,072	1864	201,012	0	201,012
NHS Wales Transfers	0	(1,428)	0	(29)	(172)	(9)	(23,047)	-5	(24,690)	0	(24,690)
Prepayments	0	0	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note											
At 1 April 2021	17,463	71,448	270	23,286	36,571	6,400	19,025	1,859	176,322	0	176,322
Indexation	214	3,333	13	0	0	0	0	0	3,560	0	3,560
Additions - purchased	0	8,628	0	8,459	2,500	1,502	2,171	7	23,267	0	23,267
Additions - donated	0	0	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	79	1,077	0	0	5,933	70	31	0	7,190	0	7,190
Reclassifications	0	2	0	(2,081)	0	0	0	0	(2,079)	0	(2,079)
Revaluation	0	0	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,596)	(62)	(19)	0	(1,677)	0	(1,677)
At 31 March 2022	17,756	84,488	283	29,664	43,408	7,910	21,208	1,866	206,583	0	206,583
Depreciation											
At 1 April 2021	0	10,950	36	0	23,936	3,288	12,562	889	51,661	0	51,661
Indexation	0	485	1	0	0	0	0	0	486	0	486
Transfers from/(into) other NHS bodies	0	415	0	0	3,322	70	29	0	3,836	0	3,836
Reclassifications	0	0	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,565)	(62)	(19)	0	(1,646)	0	(1,646)
Charged during the year	0	3,120	9	0	3,170	664	1,970	177	9,110	0	9,110
At 31 March 2022	0	14,970	46	0	28,863	3,960	14,542	1,066	63,447	0	63,447
Net book value											
At 1 April 2021	17,463	60,498	234	23,286	12,635	3,112	6,463	970	124,661	0	124,661
Net book value											
At 31 March 2022	17,756	69,518	237	29,664	14,545	3,950	6,666	800	143,136	0	143,136
Net book value at 31 March 2022 comprises :											
Purchased	17,756	65,002	237	29,664	14,496	3,950	6,660	800	138,565	0	138,565
Donated	0	4,516	0	0	49	0	6	0	4,571	0	4,571
Government Granted	0	0	0	0	0	0	0	0	0	0	0
At 31 March 2022	17,756	69,518	237	29,664	14,545	3,950	6,666	800	143,136	0	143,136
Asset Financing:											
Owned	17,756	69,518	237	29,664	14,545	3,950	6,666	800	143,136	0	143,136
Held on finance lease	0	0	0	0	0	0	0	0	0	0	0
On-SoFP PFI contract	0	0	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0	0	0
At 31 March 2022	17,756	69,518	237	29,664	14,545	3,950	6,666	800	143,136	0	143,136

The net book value of land, buildings and dwellings at 31 March 2022 comprises :

	£000	£000	£000
Freehold	66,047	0	66,047
Long Leasehold	21,464	0	21,464
Short Leasehold	0	0	0
Total	87,511	0	87,511
Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account.	0	0	0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

13. Property, plant and equipment :

Disclosures:

i) Donated Assets
The Trust received no donated assets during the financial year 2022-23.

ii) Valuations
The Trust's land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The Trust is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

The next District Valuation is due to take place during 2027-2028.

iii) Asset Lives
Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation
There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs
Impairments and revaluations are shown in the body of note 13.

vi) The Trust does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or Sold in the Period
The Trust does not hold any assets for sale at the end of the financial year.

vii) Consultancy Services
The Trust capitalised a total of £827k of consultancy services during the financial year (including £773k related to the new hospital project and £48k to NWSSP).

Gain/(Loss) on Sale

Asset description	Reason for sale	Gain/(Loss) on sale £000
Van	Insurance write-off	**3**
		3

13.2 Non-current assets held for sale

	Land	Buildings, including dwellings	Other property plant and equipment	Intangible assets	Other assets	Total	FHoT assets	Consolidated Total
	£000	£000	£000	£000	£000	£000	£000	£000
Balance b/f 1 April 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Plus assets classified as held for sale in year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less assets sold in year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Plus reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less impairment for assets held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less assets no longer classified as held for sale for reasons other than disposal by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance c/f 31 March 2023	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance b/f 1 April 2021	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in year	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0
Less assets sold in year	0	0	0	0	0	0	0	0
Plus reversal of impairments	0	0	0	0	0	0	0	0
Less impairment for assets held for sale	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale for reasons other than disposal by sale	0	0	0	0	0	0	0	0
Balance c/f 31 March 2022	0	0	0	0	0	0	0	0

13.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, the following are significant in their own right, all included in Land & Buildings:

	NBV at 31/03/2023
NWSSP Unit IP5 Imperial Park, Newport	£8,162,000
NWSSP Greenvale Laundry, Llanfrechfa	£2,460,000
NWSSP Alder House, St Asaph,	£1,176,000
NWSSP Bridgend Stores, Bridgend	£507,000
NWSSP Surgical Materials Testing Laboratory, Bridgend	£562,000
NWSSP Companies House, 4th floor	£275,000
NWSSP Unit 25 Samlet Road, Swansea	£245,000
NWSSP Glan Clwyd Laundry, Rhyl	£234,000

2022-23	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000	FHoT Assets £000	Consolidated Total £000
Cost or valuation at 31 March	0	0	0	0	0	0	0	0	**0**	0	**0**
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	**0**	0	**0**
Transfer of Finance Leases from PPE Note	0	12,133	0	0	0	0	0	0	**12,133**	0	**12,133**
Operating Leases Transitioning	0	7,439	0	0	595	24	0	0	**8,058**	0	**8,058**
Cost or valuation at 1 April	**0**	**19,572**	**0**	**0**	**595**	**24**	**0**	**0**	**20,191**	**0**	**20,191**
Additions	0	98	0	0	8	0	0	0	**106**	0	**106**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**	0	**0**
Impairments	0	-3,816	0	0	0	0	0	0	**-3,816**	0	**-3,816**
De-recognition	0	0	0	0	0	0	0	0	**0**	0	**0**
At 31 March	**0**	**15,854**	**0**	**0**	**603**	**24**	**0**	**0**	16,481	**0**	16,481
Depreciation at 31 March	0	0	0	0	0	0	0	0	**0**	0	**0**
Transfer of Finance Leases from PPE Note	0	910	0	0	0	0	0	0	**910**	0	**910**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**	0	**0**
Depreciation at 1 April	**0**	**910**	**0**	**0**	**0**	**0**	**0**	**0**	910	**0**	910
Recognition	0	0	0	0	0	0	0	0	**0**	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**	0	**0**
Impairments	0	-910	0	0	0	0	0	0	**-910**	0	**-910**
De-recognition	0	0	0	0	0	0	0	0	**0**	0	**0**
Provided during the year	0	1,497	0	0	169	12	0	0	**1,678**	0	**1,678**
At 31 March	**0**	**1,497**	**0**	**0**	**169**	**12**	**0**	**0**	1,678	**0**	1,678
Net book value at 1 April	**0**	**18,662**	**0**	**0**	**595**	**24**	**0**	**0**	19,281	**0**	19,281
Net book value at 31 March	**0**	**14,357**	**0**	**0**	**434**	**12**	**0**	**0**	14,803	**0**	14,803

	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000	FHoT Assets £000	Consolidated Total £000
RoU Asset Total Value Split by Lessor											
NHS Wales Peppercorn Leases	0	3,281	0	0	0	0	0	0	**3,281**	0	**3,281**
NHS Wales Market Value Leases	0	482	0	0	0	0	0	0	**482**	0	**482**
Other Public Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**	0	**0**
Other Public Sector Market Value Leases	0	440	0	0	0	0	0	0	**440**	0	**440**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**	0	**0**
Private Sector Market Value Leases	0	10,154	0	0	434	12	0	0	**10,600**	0	**10,600**
Total	**0**	**14,357**	**0**	**0**	**434**	**12**	**0**	**0**	14,803	**0**	14,803

13.3 Right of Use Assets

Quantitative disclosures

Maturity analysis Contractual undiscounted cash flows relating to lease liabilities	£000
Less than 1 year	1,148
2-5 years	1,819
> 5 years	687
Total	**3,654**

Lease Liabilities (net of irrecoverable VAT)	£000
Current	1,123
Non-Current	2,420
Total	**3,543**

Amounts Recognised in Statement of Comprehensive Net Expenditure	£000
Depreciation	1,676
Impairment	1,894
Variable lease payments not included in lease liabilities - Interest expense	40
Sub-leasing income	0
Expense related to short-term leases	369
Expense related to low-value asset leases (excluding short-term leases)	60

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)	£000
Interest expense	40
Repayments of principal on leases	1,366
Total	**1,406**

14. Intangible assets

	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Assets under Construction	Total	FHoT	Consolidated Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 31 March bf	7,907	4,321	1,342	0	0	0	13,570	0	13,570
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
At 1 April 2022	7,907	4,321	1,342	0	0	0	13,570	0	13,570
Revaluation		0			0	0	0	0	0
Reclassifications	(113)	0	0	0	0	0	(113)	0	(113)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	(348)	0	0	0	0	0	(348)	0	(348)
Additions									
- purchased	1,934	581	1,786	0	0	0	4,301	0	4,301
- internally generated	0	0	0	0	0	0	0	0	0
- donated	0	0	0	0	0	0	0	0	0
- government granted	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	(354)	0	(196)	0	0	0	(550)	0	(550)
At 31 March 2023	9,026	4,902	2,932	0	0	0	16,860	0	16,860
Amortisation									
Amortisation at 31 March bf	3,304	343	1,256	0	0	0	4,903	0	4,903
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset N	0	0	0	0	0	0	0	0	0
At 1 April 2022	3,304	343	1,256	0	0	0	4,903	0	4,903
Revaluation		0			0	0	0	0	0
Reclassifications	(45)	0	0	0	0	0	(45)	0	(45)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Charged during the year	1,043	249	66	0	0	0	1,358	0	1,358
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	(354)	0	(196)	0	0	0	(550)	0	(550)
Accumulated amortisation at 31 March 2023	3,948	592	1,126	0	0	0	5,666	0	5,666
Net book value At 1 April 2022	4,603	3,978	86	0	0	0	8,667	0	8,667
Net book value At 31 March 2023	5,078	4,310	1,806	0	0	0	11,194	0	11,194
Net book value									
Purchased	5,076	4,310	1,806	0	0	0	11,192	0	11,192
Donated	2	0	0	0	0	0	2	0	2
Government granted	0	0	0	0	0	0	0	0	0
Internally Generated	0	0	0	0	0	0	0	0	0
At 31 March 2023	5,078	4,310	1,806	0	0	0	11,194	0	11,194

14. Intangible assets

	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Assets under Construction	Total	FHoT	Consolidated Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 31 March bf	42,122	6,710	4,658	0	0	0	53,490	0	53,490
NHS Wales Transfers	(37,352)	(4,183)	(3,319)	0	0	0	(44,854)	0	(44,854)
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
At 1 April 2021	**4,770**	**2,527**	**1,339**	**0**	**0**	**0**	**8,636**	**0**	**8,636**
Revaluation		0			0	0	0	0	**0**
Reclassifications	1,340	739	0	0	0	0	2,079	0	**2,079**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Additions									
- purchased	1,797	1,055	3	0	0	0	2,855	0	**2,855**
- internally generated	0	0	0	0	0	0	0	0	**0**
- donated	0	0	0	0	0	0	0	0	**0**
- government granted	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
At 31 March 2022	7,907	4,321	1,342	0	0	0	13,570	0	**13,570**
Amortisation									
Amortisation at 31 March bf	26,793	1,759	4,117	0	0	0	32,669	0	**32,669**
NHS Wales Transfers	(24,344)	(1,528)	(3,006)	0	0	0	(28,878)	0	**(28,878)**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	**0**
At 1 April 2021	**2,449**	**231**	**1,111**	**0**	**0**	**0**	**3,791**	**0**	**3,791**
Revaluation		0			0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Charged during the year	855	112	145	0	0	0	1,112	0	**1,112**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Accumulated amortisation at 31 March 2022	**3,304**	**343**	**1,256**	**0**	**0**	**0**	**4,903**	**0**	**4,903**
Net book value At 1 April 2021	**2,321**	**2,296**	**228**	**0**	**0**	**0**	**4,845**	**0**	**4,845**
Net book value At 31 March 2022	**4,603**	**3,978**	**86**	**0**	**0**	**0**	**8,667**	**0**	**8,667**
Net book value									
Purchased	4,599	3,978	86	0	0	0	8,663	0	**8,663**
Donated	4	0	0	0	0	0	4	0	**4**
Government granted	0	0	0	0	0	0	0	0	**0**
Internally Generated	0	0	0	0	0	0	0	0	**0**
At 31 March 2022	**4,603**	**3,978**	**86**	**0**	**0**	**0**	**8,667**	**0**	**8,667**

14. Intangible assets

Disclosures:

i) Donated Assets
There were no intangible assets donated or received by Government Grant this financial year.

ii) Recognition
Intangible assets comprise of licences for use of purchased IT software such as financial systems, internally generated IT software and various licences and trade marks.

An assessment is performed on an annual basis to determine that the assets are still available for use and that there is a continued market for their use. The fair values are based on the original cost and amortised based upon finite lives detailed below, and are as detailed in the notes to the accounts.

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

iii) Asset Lives
The useful economic life (UEL) of intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL and the UEL of internally generated software is based on the professional judgement of Trust professionals and Finance staff. No intangible assets are assessed as having indefinite useful lives.

iv) Additions During the Period
Intangible additions were acquired from All Wales & Discretionary funding during the year, and have been analysed into the relevant categories.

v) Disposals During the Period
The Trust disposed of some software and licences during the year, all of which had net book values of nil.

15. Impairments

Impairments in the period arose from:	2022-23 Property, plant & equipment £000	2022-23 Right of Use Assets £000	2022-23 Intangible assets £000	2021-22 Property, plant & equipment £000	2021-22 Right of Use Assets £000	2021-22 Intangible assets £000
Loss or damage from normal operations	**0**	**0**	**0**	0		0
Abandonment of assets in the course of construction	**996**	**0**	**348**	0		0
Over specification of assets (Gold Plating)	**0**	**0**	**0**	0		0
Loss as a result of a catastrophe	**0**	**0**	**0**	0		0
Unforeseen obsolescence	**0**	**0**	**0**	0		0
Changes in market price	**125**	**1,894**	**0**	0		0
Other	**0**	**0**	**0**	0		0
Reversal of impairment	**0**	**0**	**0**	0		0
Impairments charged to operating expenses	**1,121**	**1,894**	**348**	0		0
FHoT Impairments charged to operating expenses	**0**	**0**	**0**	0		0
Consolidated impairment charged to operating expenses	**1,121**	**1,894**	**348**	**0**		**0**
Analysis of impairments :						
Operating expenses in Statement of Comprehensive Income	**1,121**	**1,894**	**348**	0		0
Revaluation reserve	**0**	**1,010**	**0**	0		0
Total	**1,121**	**2,904**	**348**	0		0
FHoT Operating expenses in SoCNI	**0**	**0**	**0**	0		0
FHoT reserves	**0**	**0**	**0**	0		0
NHS Consolidated Total	**1,121**	**2,904**	**348**	0		0

£0.995m relates to exploratory costs for the All Wales Laundry capital scheme to reach OBC stage, which has now been abandoned following Welsh Government confirmation that there is insufficient capital funding for the programme to proceed as planned. £0.348m relates to the abandonment of a capital project due to a supplier issue which is progressing to legal proceedings. £1.894m is in respect of the impairment of the IP5 warehouse to the value in the District Valuer quinquennial report following the transfer to a Right of Use Asset under IFRS16 and £0.125m impairment is reported for Matrix House as a result of the District Valuer quinquennial valuation.

16. Inventories

16.1 Inventories

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Drugs	**3,384**	2,217	**3,384**	2,217
Consumables	**24,962**	57,422	**24,962**	57,422
Energy	**0**	0	**0**	0
Work in progress	**0**	0	**0**	0
Other	**5,724**	5,568	**5,724**	5,568
Total	**34,070**	65,207	**34,070**	65,207
Of which held at net realisable value:	**13,011**	2,290	**13,011**	2,290

DH Assets within other covered under	31 March 2023 Capital £000	31 March 2023 Revenue £000	31 March 2022 Capital £000	31 March 2022 Revenue £000
Memorandum of Understanding 1	**0**	**0**	227	0
Memorandum of Understanding 2	**0**	**0**	0	0
Memorandum of Understanding 3	**0**	**0**	0	0
	0	**0**	227	0

Department of Health and Social Care and National Health Commissioning Board Donated Assets

	31 March 2023 Capital £000	31 March 2023 Revenue £000	31 March 2022 Capital £000	31 March 2022 Revenue £000
At 1 April	**227**	**0**	561	544
Transferred under Memorandum of Understanding 1	**0**	**0**	0	0
Transferred under Memorandum of Understanding 2	**0**	**0**	730	86
Transferred under Memorandum of Understanding 3	**0**	**0**	1,491	0
Issued to NHS Wales bodies	**0**	**0**	(2,234)	(317)
Other Issues	**0**	**0**	(321)	(313)
AME Impairment	**0**	**0**	0	0
Returned to DH	**0**	**0**	0	0
Replacement from DH	**0**	**0**	0	0
As at 31 March	**227**	**0**	227	0

16.2 Inventories recognised in expenses

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Inventories recognised as an expense in the period	**128,716**	173,686	**128,716**	173,686
Write-down of inventories (including losses)	**19,091**	13,066	**19,091**	13,066
Reversal of write-downs that reduced the expense	**0**	0	**0**	0
Total	**147,807**	186,752	**147,807**	186,752

Of the stock balance at 31st March 2023, £13.672m relates to Covid PPE and Testing stock with the continued Welsh Government request to hold 16 weeks of PPE to provide resilience in the event of any additional Covid waves.

Due to the expansion of the NWSSP Medicines Unit during 2022/23, the stock balance now includes £1.070m of drugs stock at 31st March 2023.

£0.283m of Covid equipment stock is held at 31st March 2023, of which £0.227m was donated from DHSC in 2020/21.

The continued high value of inventories recognised as an expense in the period is reported due to (a) the quantities of PPE that have been issued from NWSSP stores during 2022/23, however this is a reduction on the 2021/22 values and (b) NICE and high cost drug purchases made by VCS in 2022/2023.

Included in the write down of inventories is a loss of £12.858m in respect of the revaluation of PPE stocks to net realisable value, in addition to the write off of £3.604m of either faulty stock or stock of no value to NHS Wales which is held for a potential donation to Africa, and £2.396m of provisions for the potential write off of items nearing their expiry date that are unlikely to be utilised given the current stock issue rates.

17. Trade and other receivables

17.1 Trade and other receivables

Current	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Welsh Government	**525,653**	457,058	**525,653**	457,058
WHSSC & EASC	**(1,754)**	81	**(1,754)**	81
Welsh Health Boards	**14,735**	15,859	**14,735**	15,859
Welsh NHS Trusts	**1,839**	710	**1,839**	710
Welsh Special Health Authorities	**2,626**	2,911	**2,626**	2,911
Non - Welsh Trusts	**118**	160	**118**	160
Other NHS	**219**	141	**219**	141
2019-20 Scheme Pays - Welsh Government Reimbursement	**170**	339	**170**	339
Welsh Risk Pool Claim reimbursement:-				
NHS Wales Secondary Health Sector	**68**	9	**68**	9
NHS Wales Primary Sector FLS Reimbursement	**0**	0	**0**	0
NHS Wales Redress	**0**	0	**0**	0
Other	**0**	0	**0**	0
Local Authorities	**26**	0	**26**	0
Capital debtors- Tangible	**0**	0	**0**	0
Capital debtors- Intangible	**0**	0	**0**	0
Other debtors	**12,866**	16,934	**12,811**	15,849
FHoT debtor			**65**	4
Provision for impairment of trade receivables	**(5,448)**	(5,276)	**(5,448)**	(5,276)
Pension Prepayments				
NHS Pensions Agency	**0**	0	**0**	0
NEST	**0**	0	**0**	0
Other prepayments	**9,831**	5,103	**9,831**	5,103
Accrued income	**4,793**	4,449	**4,793**	4,449
Sub-total	**565,742**	498,478	**565,752**	497,397
Non-current				
Welsh Government	**1,106,800**	1,091,598	**1,106,800**	1,091,598
WHSSC & EASC	**0**	0	**0**	0
Welsh Health Boards	**0**	0	**0**	0
Welsh NHS Trusts	**0**	0	**0**	0
Welsh Special Health Authorities	**0**	0	**0**	0
Non - Welsh Trusts	**0**	0	**0**	0
Other NHS	**1**	23	**1**	23
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0	**0**	0
Welsh Risk Pool Claim reimbursement				
NHS Wales Secondary Health Sector	**0**	0	**0**	0
NHS Wales Primary Sector FLS Reimbursement	**0**	0	**0**	0
NHS Wales Redress	**0**	0	**0**	0
Other	**0**	0	**0**	0
Local Authorities	**128**	128	**128**	128
Capital debtors- Tangible	**0**	0	**0**	0
Capital debtors- Intangible	**0**	0	**0**	0
Other debtors	**0**	0	**0**	0
FHoT debtor			**0**	0
Provision for impairment of trade receivables	**0**	0	**0**	0
Pension Prepayments				
NHS Pensions Agency	**0**	0	**0**	0
NEST	**0**	0	**0**	0
Other prepayments	**118**	259	**118**	259
Accrued income	**0**	0	**0**	0
Sub-total	**1,107,047**	1,092,008	**1,107,047**	1,092,008
Total trade and other receivables	**1,672,789**	1,590,486	**1,672,799**	1,589,405

The great majority of trade is with other NHS bodies. As NHS bodies are funded by Welsh Government, no credit scoring of them is considered necessary.

The value of trade receivables that are past their payment date but not impaired is £9,366,000 (£3,935,000 in 2021-22).

The Welsh Government figure for 2021-22 has been restated from £498,807 to £457,058 to ensure consistent reporting with WG. WG Payables note has also been been restated from £51,216 to £9,467.

17.2 Receivables past their due date but not impaired

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
By up to 3 months	**3,827**	2,236	**3,827**	2,236
By 3 to 6 months	**907**	1,040	**907**	1,040
By more than 6 months	**4,632**	659	**4,632**	659
Balance at end of financial year	**9,366**	3,935	**9,366**	3,935

The increase in those debts aged more than 6 months old largely relates to monies due to NWSSP for an unfulfilled PPE contract.

17.3 Expected Credit Losses (ECL) Allowance for bad and doubtful debts

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Balance at 1 April	**(5,276)**	(2,411)	**(5,276)**	(2,411)
Transfer to other NHS Wales body	**0**	0	**0**	0
Provision utilised (Amount written off during the year)	**40**	100	**40**	100
Provision written back during the year no longer required	**0**	0	**0**	0
(Increase)/Decrease in provision during year	**(291)**	(3,567)	**(291)**	(3,567)
ECL/Bad debts recovered during year	**79**	602	**79**	602
Balance at end of financial year	**(5,448)**	(5,276)	**(5,448)**	(5,276)

The value of the provision remains high as an NWSSP doubtful debt raised in March 2022 of £3.248m remains unpaid.

17.4 Receivables VAT

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Trade receivables	233	252	233	252
Other	0	0	0	0
Total	**233**	**252**	**233**	**252**

18. Other financial assets

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Current				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCI	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	0		0	
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCI	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**
Non-Current				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCI	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	**0**		**0**	
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCI	**0**	0	**5,572**	5,826
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**0**	**5,572**	**5,826**

19. Cash and cash equivalents

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Opening Balance	**30,404**	43,263	**33,116**	44,811
Net change in year	**732**	(12,859)	**619**	(11,695)
Closing Balance	**31,136**	30,404	**33,735**	33,116
Made up of:				
Cash with Government Banking Service (GBS)	**31,112**	30,385	**31,112**	30,385
Cash with Commercial banks	**0**	0	**0**	2,712
Cash in hand	**24**	19	**24**	19
Total cash	**31,136**	30,404	**31,136**	33,116
Current investments	**0**	0	**2,599**	0
Cash and cash equivalents as in SoFP	**31,136**	30,404	**33,735**	33,116
Bank overdraft - GBS	**0**	0	**0**	0
Bank overdraft - Commercial banks	**0**	0	**0**	0
Cash & cash equivalents as in Statement of Cash Flows	**31,136**	30,404	**33,735**	33,116

Current investments for the FHoT previously reported as 'cash with commercial banks' is reported in 2022/2023 as 'current investments'.

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are:

Lease Liabilities £nil
PFI liabilities £nil

The movement relates to cash, no comparative information is required by IAS 7 in 2022-23.

20. Trade and other payables at the SoFP Date	31 March 2023	31 March 2022	31 March 2023	31 March 2022
Current	£000	£000	£000	£000
	NHS Trust		Consolidated	
Welsh Government	**6,312**	9,467	**6,312**	9,467
WHSSC & EASC	**0**	877	**0**	877
Welsh Health Boards	**144,437**	163,061	**144,437**	163,061
Welsh NHS Trusts	**3,335**	3,363	**3,335**	3,363
Welsh Special Health Authorities	**1,937**	62	**1,937**	62
Other NHS	**2,553**	2,418	**2,553**	2,418
Taxation and social security payable / refunds:				
Refunds of taxation by HMRC	**0**	0	**0**	0
VAT payable to HMRC	**0**	0	**0**	0
Other taxes payable to HMRC	**4,920**	26	**4,920**	26
National Insurance contributions payable to HMRC	**5,157**	155	**5,157**	155
Non-NHS trade payables - revenue	**18,271**	22,305	**18,271**	22,305
Local Authorities	**84**	91	**84**	91
Capital payables-Tangible	**7,860**	8,097	**7,860**	8,097
Capital payables- Intangible	**1,735**	537	**1,735**	537
Overdraft	**0**	0	**0**	0
FHoT payables			**(1,476)**	48
Rentals due under operating leases	**0**	0	**0**	0
Obligations due under finance leases and HP contracts	**0**	0		0
Imputed finance lease element of on SoFP PFI contracts	**0**	0	**0**	0
Pensions: staff	**4,703**	3,918	**4,703**	3,918
Non NHS Accruals	**22,952**	20,307	**22,952**	20,307
Deferred Income:				
Deferred income brought forward	**1,167**	1,210	**1,167**	1,210
Deferred income additions	**1,458**	753	**1,458**	753
Transfer to/from current/non current deferred income	**(6)**	0	**(6)**	0
Released to the Income Statement	**(621)**	(795)	**(621)**	(795)
Other liabilities - all other payables	**0**	0	**0**	0
PFI assets – deferred credits	**0**	0	**0**	0
PFI - Payments on account	**0**	0	**0**	0
Sub-total	**226,254**	235,852	**224,778**	235,900

The Trust aims to pay all invoices within the 30 day period directed by the Welsh Government.

The Welsh Government figure for 2021-22 has been restated from £51,216 to £9,467 to ensure consistent reporting with WG. WG Trade Receivables has been restated from £498,807 to £457,058

20. Trade and other payables at the SoFP Date (cont)

Non-current	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Welsh Government	**2,500**	7,000	**2,500**	7,000
WHSSC & EASC	**0**	0	**0**	0
Welsh Health Boards	**0**	0	**0**	0
Welsh NHS Trusts	**0**	0	**0**	0
Welsh Special Health Authorities	**0**	0	**0**	0
Other NHS	**0**	0	**0**	0
Taxation and social security payable / refunds:				
Refunds of taxation by HMRC	**0**	0	**0**	0
VAT payable to HMRC	**0**	0	**0**	0
Other taxes payable to HMRC	**0**	0	**0**	0
National Insurance contributions payable to HMRC	**0**	0	**0**	0
Non-NHS trade payables - revenue	**0**	0	**0**	0
Local Authorities	**0**	0	**0**	0
Capital payables- Tangible	**0**	0	**0**	0
Capital payables- Intangible	**0**	0	**0**	0
Overdraft	**0**	0	**0**	0
FHoT payables			**0**	0
Rentals due under operating leases	**0**	0	**0**	0
Obligations due under finance leases and HP contracts	**0**	0		0
Imputed finance lease element of on SoFP PFI contracts	**0**	0	**0**	0
Pensions: staff	**0**	0	**0**	0
Non NHS Accruals	**0**	0	**0**	0
Deferred Income:				
Deferred income brought forward	**336**	301	**336**	301
Deferred income additions	**250**	35	**250**	35
Transfer to/from current/non current deferred income	**6**	0	6	0
Released to the Income Statement	**0**	0	0	0
Other liabilities - all other payables	**0**	0	0	0
PFI assets –deferred credits	**0**	0	0	0
Payments on account	**0**	0	0	0
Sub-total	**3,092**	**7,336**	**3,092**	**7,336**
Total	**229,346**	243,188	**227,870**	243,236

The WG non current creditor arose as a result of a requirement to hold additional stocks as a result of Brexit. The value has reduced in year as £4.5m stock for NWSSP was released and WG reimbursed. The remaining value relates to additional stocks still held by the Welsh Blood Service.

21. Borrowings	31 March 2023	31 March 2022	31 March 2023	31 March 2022
Current	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Bank overdraft - Government Banking Service (GBS)	**0**	0	**0**	0
Bank overdraft - Commercial bank	**0**	0	**0**	0
Loans from:				
Welsh Government	**0**	0	**0**	0
Other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0		0
RoU Lease Liability	**1,123**		**1,123**	
Other	**0**	0	**0**	0
Total	**1,123**	0	**1,123**	0
Non-current				
Bank overdraft - GBS	**0**	0	**0**	0
Bank overdraft - Commercial bank	**0**	0	**0**	0
Loans from:				
Welsh Government	**0**	0	**0**	0
Other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0		0
RoU Lease Liability	**2,421**		**2,421**	
Other	**0**	0	**0**	0
Total	**2,421**	0	**2,421**	0

RoU Lease Liability Transitioning & Transferring	**£000**
RoU liability as at 31 March 2022	**0**
Transfer of Finance Leases from PPE Note	**0**
Operating Leases Transitioning	**4,798**
RoU Lease liability as at 1 April 2022	**4,798**

The opening liability as at 1 April 2022 was £4.798m: consisting of £4.330m for NWSSP and £0.468m for the Trust core services.

21.2 Loan advance/strategic assistance funding

	31 March 2023	31 March 2022	31 March 2023	31 March 2022
Amounts falling due:	**£000**	£000	**£000**	£000
In one year or less	**0**	0	**0**	0
Between one and two years	**0**	0	**0**	0
Between two and five years	**0**	0	**0**	0
In five years or more	**0**	0	**0**	0
Sub-total	**0**	0	**0**	0
Wholly repayable within five years	**0**	0	**0**	0
Wholly repayable after five years, not by instalments	**0**	0	**0**	0
Wholly or partially repayable after five years by instalments	**0**	0	**0**	0
Sub-total	**0**	0	**0**	0
Total repayable after five years by instalments	**0**	0	**0**	0

The Trust has not received a loan advance or strategic funding from the Welsh Government.

22. Other financial liabilities

Current	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Financial Guarantees				
At amortised cost	**0**	0	**0**	0
At fair value through SoCI	**0**	0	**0**	0
Derivatives at fair value through SoCI	**0**	0	**0**	0
Other				
At amortised cost	**0**	0	**0**	0
At fair value through SoCI	**0**	0	**0**	0
Total	**0**	0	**0**	0

Non-current	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Financial Guarantees				
At amortised cost	**0**	0	**0**	0
At fair value through SoCI	**0**	0	**0**	0
Derivatives at fair value through SoCI	**0**	0	**0**	0
Other				
At amortised cost	**0**	0	**0**	0
At fair value through SoCI	**0**	0	**0**	0
Total	**0**	0	**0**	0

23. Provisions

2022-23

Current	At 1 April 2022	Structured settlement cases transferr-ed to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	308,483	(40,291)	(33,716)	48,409	0	227,939	(61,159)	(88,156)	(4,637)	356,872
Primary Care	133	0	0	0	0	639	(69)	(72)	0	631
Redress Secondary Care	2,300	0	(366)	8	0	3,638	(1,183)	(1,276)	0	3,121
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	3,803	0	(8)	(197)	0	4,196	(1,821)	(2,333)	0	3,640
All other losses and special payments	0	0	0	0	0	16,839	(16,839)	0	0	0
Defence legal fees and other administration	5,404	0	0	363	0	4,315	(1,791)	(2,563)	0	5,728
Structured Settlements - WRPS	18,070	1,247	0	0	0	24,219	(19,116)	(679)	(4,323)	19,418
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	15		(5)	20	0	0	(17)	0	0	13
2019-20 Scheme Pays - Reimbursement	2		0	0	0	1	0	(2)	0	1
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	2,913		0	569	0	3,244	0	(3,625)		3,101
Total	341,123	(39,044)	(34,095)	49,172	0	285,030	(101,995)	(98,706)	(8,960)	392,525
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	341,123	(39,044)	(34,095)	49,172	0	285,030	(101,995)	(98,706)	(8,960)	392,525
Non Current										
Clinical negligence:-										
Secondary Care	472,825	0	(400)	(48,687)	0	100,677	(15,318)	(27,945)	0	481,152
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	12	0	0	(12)	0	3	0	0	0	3
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	0	0	0	195	0	403	(247)	(139)	0	212
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	3,656	0	0	(79)	0	1,591	(292)	(599)	0	4,277
Structured Settlements - WRPS	615,107	39,044	0	0	0	13,489	0	(46,483)	0	621,157
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	53		0	(20)	0	9	0	0	0	42
2019-20 Scheme Pays - Reimbursement	337		0	0	0	169	0	(337)	0	169
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	2,216		0	(569)	0	780	0	(520)		1,907
Total	1,094,206	39,044	(400)	(49,172)	0	117,121	(15,857)	(76,023)	0	1,108,919
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,094,206	39,044	(400)	(49,172)	0	117,121	(15,857)	(76,023)	0	1,108,919
TOTAL										
Clinical negligence:-										
Secondary Care	781,308	(40,291)	(34,116)	(278)	0	328,616	(76,477)	(116,101)	(4,637)	838,024
Primary Care	133	0	0	0	0	639	(69)	(72)	0	631
Redress Secondary Care	2,312	0	(366)	(4)	0	3,641	(1,183)	(1,276)	0	3,124
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	3,803	0	(8)	(2)	0	4,599	(2,068)	(2,472)	0	3,852
All other losses and special payments	0	0	0	0	0	16,839	(16,839)	0	0	0
Defence legal fees and other administration	9,060	0	0	284	0	5,906	(2,083)	(3,162)	0	10,005
Structured Settlements - WRPS	633,177	40,291	0	0	0	37,708	(19,116)	(47,162)	(4,323)	640,575
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	68		(5)	0	0	9	(17)	0	0	55
2019-20 Scheme Pays - Reimbursement	339		0	0	0	170	0	(339)	0	170
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	5,129		0	0	0	4,024	0	(4,145)		5,008
Total	1,435,329	0	(34,495)	0	0	402,151	(117,852)	(174,729)	(8,960)	1,501,444
FH0T	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,435,329	0	(34,495)	0	0	402,151	(117,852)	(174,729)	(8,960)	1,501,444

Expected timing of cash flows:

	In year to 31 March 2024	Between 01-Apr-24 to 31 March 2028	Thereafter	Totals
	£000	£000	£000	£000
Clinical negligence:-				
Secondary Care	356,872	363,883	117,269	838,024
Primary Care	631	0	0	631
Redress Secondary Care	3,121	3	0	3,124
Redress Primary Care	0	0	0	0
Personal injury	3,640	212	0	3,852
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	5,728	4,277	0	10,005
Structured Settlements - WRPS	19,418	83,967	537,190	640,575
Pensions - former directors	0	0	0	0
Pensions - other staff	13	42	0	55
2019-20 Scheme Pays - Reimbursement	1	2	167	170
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Other	3,101	1,461	446	5,008
Total	392,525	453,847	655,072	1,501,444
FHoT	0	0	0	0
Consolidated Total	392,525	453,847	655,072	1,501,444

23. Provisions NHS Trust
2022-23

Current	At 1 April 2022	Structured settlement cases transferr-ed to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	90	0	0	0	0	1,723	0	(90)	0	1,723
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	26	0	0	0	0	19	0	(22)	0	23
All other losses and special payments	0	0	0	0	0	16,839	(16,839)	0	0	0
Defence legal fees and other administration	89	0	0	0	0	197	0	(92)	0	194
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	15		(5)	21	0	0	(17)	0	0	14
2019-20 Scheme Pays - Reimbursement	2		0	0	0	1	0	(2)	0	1
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	2,914		0	569	0	3,245	0	(3,624)		3,104
Total	3,136	0	(5)	590	0	22,024	(16,856)	(3,830)	0	5,059
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	3,136	0	(5)	590	0	22,024	(16,856)	(3,830)	0	5,059
Non Current										
Clinical negligence:-										
Secondary Care	0	0	0	0	0	0	0	0	0	0
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	0	0	0	0	0	0	0	0	0	0
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	0	0	0	0	0	0	0	0	0	0
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	53		0	(20)	0	9	0	0	0	42
2019-20 Scheme Pays - Reimbursement	337		0	0	0	169	0	(337)	0	169
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	2,216		0	(569)	0	780	0	(520)		1,907
Total	2,606	0	0	(589)	0	958	0	(857)	0	2,118
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	2,606	0	0	(589)	0	958	0	(857)	0	2,118
TOTAL										
Clinical negligence:-										
Secondary Care	90	0	0	0	0	1,723	0	(90)	0	1,723
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	26	0	0	0	0	19	0	(22)	0	23
All other losses and special payments	0	0	0	0	0	16,839	(16,839)	0	0	0
Defence legal fees and other administration	89	0	0	0	0	197	0	(92)	0	194
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	68		(5)	1	0	9	(17)	0	0	56
2019-20 Scheme Pays - Reimbursement	339		0	0	0	170	0	(339)	0	170
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	5,130		0	0	0	4,025	0	(4,144)		5,011
Total	5,742	0	(5)	1	0	22,982	(16,856)	(4,687)	0	7,177
FH0T	0	0	0	0	0	0	0	0	0	0
Consolidated Total	5,742	0	(5)	1	0	22,982	(16,856)	(4,687)	0	7,177

Expected timing of cash flows:

	In year to 31 March 2024	Between 01-Apr-24 to 31 March 2028	Thereafter	Totals
	£000	£000	£000	£000
Clinical negligence:-				
Secondary Care	1,723	0	0	1,723
Primary Care	0	0	0	0
Redress Secondary Care	0	0	0	0
Redress Primary Care	0	0	0	0
Personal injury	23	0	0	23
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	194	0	0	194
Structured Settlements - WRPS	0	0	0	0
Pensions - former directors	0	0	0	0
Pensions - other staff	14	42	0	56
2019-20 Scheme Pays - Reimbursement	1	2	167	170
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Other	3,104	1,461	446	5,011
Total	5,059	1,505	613	7,177
FHoT	0	0	0	0
Consolidated Total	5,059	1,505	613	7,177

23. Provisions WRP
2022-23

Current	At 1 April 2022	Structured settlement cases transferr-ed to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	308,391	(40,291)	(33,716)	48,409	0	226,216	(61,159)	(88,066)	(4,637)	355,147
Primary Care	133	0	0	0	0	639	(69)	(72)	0	631
Redress Secondary Care	2,301	0	(366)	8	0	3,638	(1,183)	(1,276)	0	3,122
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	3,777	0	(8)	(197)	0	4,177	(1,821)	(2,311)	0	3,617
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	5,316	0	0	363	0	4,118	(1,791)	(2,471)	0	5,535
Structured Settlements - WRPS	18,070	1,247	0	0	0	24,219	(19,116)	(679)	(4,323)	19,418
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	0		0	0	0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	337,988	(39,044)	(34,090)	48,583	0	263,007	(85,139)	(94,875)	(8,960)	387,470
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	337,988	(39,044)	(34,090)	48,583	0	263,007	(85,139)	(94,875)	(8,960)	387,470
Non Current										
Clinical negligence:-										
Secondary Care	472,825	0	(400)	(48,687)	0	100,677	(15,318)	(27,945)	0	481,152
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	12	0	0	(12)	0	3	0	0	0	3
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	0	0	0	195	0	403	(247)	(139)	0	212
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	3,655	0	0	(79)	0	1,590	(292)	(599)	0	4,275
Structured Settlements - WRPS	615,107	39,045	0	0	0	13,489	0	(46,483)	0	621,158
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	0		0	0	0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	1,091,599	39,045	(400)	(48,583)	0	116,162	(15,857)	(75,166)	0	1,106,800
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,091,599	39,045	(400)	(48,583)	0	116,162	(15,857)	(75,166)	0	1,106,800
TOTAL										
Clinical negligence:-										
Secondary Care	781,216	(40,291)	(34,116)	(278)	0	326,893	(76,477)	(116,011)	(4,637)	836,299
Primary Care	133	0	0	0	0	639	(69)	(72)	0	631
Redress Secondary Care	2,313	0	(366)	(4)	0	3,641	(1,183)	(1,276)	0	3,125
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	3,777	0	(8)	(2)	0	4,580	(2,068)	(2,450)	0	3,829
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	8,971	0	0	284	0	5,708	(2,083)	(3,070)	0	9,810
Structured Settlements - WRPS	633,177	40,292	0	0	0	37,708	(19,116)	(47,162)	(4,323)	640,576
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	0		0	0	0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	1,429,587	1	(34,490)	0	0	379,169	(100,996)	(170,041)	(8,960)	1,494,270
FH0T	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,429,587	1	(34,490)	0	0	379,169	(100,996)	(170,041)	(8,960)	1,494,270

Expected timing of cash flows:

	In year to 31 March 2024 £000	Between 01-Apr-24 to 31 March 2028 £000	Thereafter £000	Totals £000
Clinical negligence:-				
Secondary Care	355,147	363,885	117,269	836,301
Primary Care	631	0	0	631
Redress Secondary Care	3,122	3	0	3,125
Redress Primary Care	0	0	0	0
Personal injury	3,617	211	0	3,828
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	5,535	4,274	0	9,809
Structured Settlements - WRPS	19,418	83,967	537,191	640,576
Pensions - former directors	0	0	0	0
Pensions - other staff	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0	0	0	0
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	
Other Capital Provisions	0	0	0	
Other	0	0	0	0
Total	387,470	452,340	654,460	1,494,270
FHoT	0	0	0	0
Consolidated Total	387,470	452,340	654,460	1,494,270

The provisions relate to amounts over £25,000 in respect of ongoing claims against the NHS in Wales, the outcome of which will not be determined until the case has been finalised.

Timings of cashflow have been profiled to match total current liabilities. However, the total will include cases which may settle with a structured settlement, so the underlying cashflows will be over a number of years. Also, there can be delays in settlement dates anticipated for next year which will further impact the cashflow timings.

23. Provisions (continued)

2021-22

NHS Trust and Welsh Risk Pool

	At 1 April 2021	Structured settlement cases transferred to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2022
Current										
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	286,428	(56,929)	(8,495)	(9,360)	0	285,210	(94,727)	(93,594)	(50)	308,483
Primary Care	122	0	0	0	0	134	(81)	(42)	0	133
Redress Secondary Care	2,843	0	227	(10)	0	3,176	(1,712)	(2,224)	0	2,300
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	6,428	0	(229)	1,292	0	5,932	(1,911)	(7,709)	0	3,803
All other losses and special payments	0	0	0	0	0	23,441	(23,441)	0	0	0
Defence legal fees and other administration	5,590	0	0	420	0	3,725	(1,930)	(2,401)	0	5,404
Structured Settlements - WRPS	15,111	1,700	0	0	0	18,568	(16,645)	(1,807)	1,143	18,070
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	18		(6)	22	0	0	(19)	0	0	15
2019-20 Scheme Pays - Reimbursement	0		0	0	0	2	0	0	0	2
Restructurings	0		0	0	0	0	0	0		0
Other	419		0	0	0	3,311	0	(817)		2,913
Total	316,959	(55,229)	(8,503)	(7,636)	0	343,499	(140,466)	(108,594)	1,093	341,123
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	316,959	(55,229)	(8,503)	(7,636)	0	343,499	(140,466)	(108,594)	1,093	341,123
Non Current										
Clinical negligence:-										
Secondary Care	359,188	0	0	9,195	0	130,985	(3,100)	(23,443)	0	472,825
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	6	0	0	9	0	10	(2)	(11)	0	12
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	1,292	0	0	(1,292)	0	0	0	0	0	0
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	3,289	0	0	(254)	0	1,026	(112)	(293)	0	3,656
Structured Settlements - WRPS	452,672	55,229	0	0	0	108,342	0	(1,136)	0	615,107
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	71		0	(22)	0	4	0	0	0	53
2019-20 Scheme Pays - Reimbursement	0		0	0	0	337	0	0	0	337
Restructurings	0		0	0	0	0	0	0		0
Other	2,264		0	0	0	642	0	(690)		2,216
Total	818,782	55,229	0	7,636	0	241,346	(3,214)	(25,573)	0	1,094,206
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	818,782	55,229	0	7,636	0	241,346	(3,214)	(25,573)	0	1,094,206
TOTAL										
Clinical negligence:-										
Secondary Care	645,616	(56,929)	(8,495)	(165)	0	416,195	(97,827)	(117,037)	(50)	781,308
Primary Care	122	0	0	0	0	134	(81)	(42)	0	133
Redress Secondary Care	2,849	0	227	(1)	0	3,186	(1,714)	(2,235)	0	2,312
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	7,720	0	(229)	0	0	5,932	(1,911)	(7,709)	0	3,803
All other losses and special payments	0	0	0	0	0	23,441	(23,441)	0	0	0
Defence legal fees and other administration	8,879	0	0	166	0	4,751	(2,042)	(2,694)	0	9,060
Structured Settlements - WRPS	467,783	56,929	0	0	0	126,910	(16,645)	(2,943)	1,143	633,177
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	89		(6)	0	0	4	(19)	0	0	68
2019-20 Scheme Pays - Reimbursement	0		0	0	0	339	0	0	0	339
Restructurings	0		0	0	0	0	0	0		0
Other	2,683		0	0	0	3,953	0	(1,507)		5,129
Total	1,135,741	0	(8,503)	0	0	584,845	(143,680)	(134,167)	1,093	1,435,329
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,135,741	0	(8,503)	0	0	584,845	(143,680)	(134,167)	1,093	1,435,329

24 Contingencies

24.1 Contingent liabilities

Provision has not been made in these accounts for the following amounts:	**31 March 2023 £000**	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
	NHS Trust		**Consolidated**	
Legal claims for alleged medical or employer negligence;				
Secondary care	**1,172,097**	1,252,357	**1,172,097**	1,252,357
Primary Care	**6,351**	1,790	**6,351**	1,790
Secondary care - Redress	**1,539**	712	**1,539**	712
Primary Care - Redress	**0**	0	**0**	0
Doubtful debts	**0**	0	**0**	0
Equal pay cases	**0**	0	**0**	0
Defence costs	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total value of disputed claims	**1,179,987**	1,254,859	**1,179,987**	1,254,859
Amount recovered under insurance arrangements in the event of these claims being successful	**(1,179,711)**	(1,254,460)	**(1,179,711)**	(1,254,460)
Net contingent liability	**276**	399	**276**	399

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Contingent liabilities includes claims relating to alleged clinical negligence, personal injury and permanent injury benefits under the NHS Injury Benefits Scheme. The above figures include contingent liabilities for all Health Bodies in Wales.

24.2. Remote contingent liabilities

	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
	NHS Trust		**Consolidated**	
Guarantees	**0**	0	0	0
Indemnities	**102,503**	60,204	**102,503**	60,204
Letters of comfort	**0**	0	0	0
Total	**102,503**	60,204	**102,503**	60,204

24.3 Contingent assets

	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
	NHS Trust		**Consolidated**	
	0	0	**0**	0
	0	0	**0**	0
	0	0	**0**	0
	0	**0**	**0**	**0**

The Trust has no contingent assets.

25. Capital commitments

Commitments under capital expenditure contracts at the statement of financial position sheet date:
The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	31 March 2023	31 March 2022	**31 March 2023**	31 March 2022
	NHS Trust		**Consolidated**	
	£000	£000	**£000**	£000
Property, plant and equipment	**38,598**	19,553	**38,598**	19,553
Right of Use Assets	**0**		**0**	
Intangible assets	**6,068**	83	**6,068**	83
Total	**44,666**	19,636	**44,666**	19,636

The Capital commitments include contract obligations of £32m in respect of the Integrated Radiotherapy Solution project and £11m for the enabling works at the new hospital site development.

26. Losses and special payments

Losses and special payments are charged to the Income statement in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during year to 31 March 2023	
	Number	£
Clinical negligence	402	129,272,440
Personal injury	68	2,466,371
All other losses and special payments	338	20,023,038
Structured Settlements managed by WRP	264	19,483,889
Total	**1,072**	**171,245,738**
FHoT losses and special payments	**0**	**0**
Consolidated Total	**1,072**	**171,245,738**

Analysis of cases in excess of £300,000

	Case Type	In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
		Number	£	Number	£
Cases in excess of £300,000:					
Velindre University NHS Trust	Losses & Special Payments; Clinical Negligence	5	16,733,415	6	17,037,361
WRP - Secondary Care:					
Secondary Care					
Aneurin Bevan UHB	Clinical Negligence	8	16,766,241	8	16,766,241
Betsi Cadwaladr UHB	Clinical Negligence	16	27,038,030	16	27,396,834
Cardiff and Vale UHB	Clinical Negligence; Personal Injury	14	19,978,044	14	19,978,044
Cwm Taf Morgannwg UHB	Clinical	14	21,872,901	14	31,708,369
Hywel Dda UHB	Clinical Negligence	10	11,703,490	10	13,113,726
Swansea Bay UHB	Clinical Negligence	10	8,684,908	10	12,217,878
Welsh Ambulance Service NHS Trust	Clinical Negligence	2	1,150,953	2	1,150,953
Sub-total		**79**	**123,927,982**	**80**	**139,369,406**
All other cases		986	44,857,336	986	119,254,282
Structured Settlements managed by WRP		7	2,460,420	7	16,870,060
Total cases		**1,072**	**171,245,738**	**1,073**	**275,493,748**

The Welsh Risk Pool (WRP) reimburses Trusts, Local Health Boards and Special Health Authorities for payments made in year. The WRP also manages annual payments directly to WRP claimants. They arise when a case settles with a Structured Settlement arrangement. The comparative figure of annual payments for 2021/22 is **£16,644,570** for **235** transactions**.** Structured settlements relate to cases which have settled with a lower lump sum element within the total settlement value, plus annual payments over the lifetime of the claimant (the Periodical Payment Order). They typically relate to high value cases over £1M and are primarily used to meet the future care costs of the claimant as they fall due.

26.2 Velindre NHS Trust excluding WRP Losses and special payments

Losses and special payments are charged to the Income statement in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during year to 31 March 2023	
	Number	**£**
Clinical negligence	4	157,022
Personal injury	2	1,367
All other losses and special payments	9	16,879,531
Structured Settlements managed by WRP	0	0
Total	**15**	**17,037,920**
FHoT losses and special payments	**0**	**0**
Consolidated Total	**15**	**17,037,920**

Analysis of cases in excess of £300,000

	In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
	Number	**£**	**Number**	**£**
Cases in excess of £300,000:				
Clinical Negligence	0	0	1	303,946
Other Losses	5	16,733,415	5	16,733,415
Sub-total	**5**	**16,733,415**	**6**	**17,037,361**
All other cases	10	304,505	9	702,122
Total cases	**15**	**17,037,920**	**15**	**17,739,483**

Other losses include stock revaluations of £12.9m and stock losses of £3.6m

26. 3 WRP Losses and special payments

Losses and special payments are charged to the Income statement in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during year to 31 March 2023	
	Number	£
Clinical negligence	398	129,115,418
Personal injury	66	2,465,004
All other losses and special payments	329	3,143,507
Structured Settlements managed by WRP	264	19,483,889
Total	**1,057**	**154,207,818**
FHoT losses and special payments	**0**	**0**
Consolidated Total	**1,057**	**154,207,818**

Analysis of cases in excess of £300,000

		In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
		Number	£	Number	£
Cases in excess of £300,000:					
Secondary Care					
Aneurin Bevan UHB	Clinical Negligence	8	16,766,241	8	16,766,241
Betsi Cadwaladr UHB	Clinical Negligence	16	27,038,030	16	27,396,834
Cardiff and Vale UHB	Clinical Negligence; Personal Injury	14	19,978,044	14	19,978,044
Cwm Taf Morgannwg UHB	Clinical Negligence	14	21,872,901	14	31,708,369
Hywel Dda UHB	Clinical Negligence	10	11,703,490	10	13,113,726
Swansea Bay UHB	Clinical Negligence	10	8,684,908	10	12,217,878
Welsh Ambulance Service NHS Trust	Clinical Negligence	2	1,150,953	2	1,150,953
Primary Care		0	0	0	0
Sub-total		**74**	**107,194,567**	**74**	**122,332,045**
WRP Managed Structured Settlements		7	2,460,420	7	16,870,060
All other cases		976	**44,552,831**	**976**	118,552,160
Total cases		**1,057**	**154,207,818**	**1,057**	**257,754,265**

The Welsh Risk Pool (WRP) reimburses Trusts, Local Health Boards and Special Health Authorities for payments made in year. The WRP also manages annual payments directly to WRP claimants. They arise when a case settles with a Structured Settlement arrangement. The comparative figure of annual payments for 2021/22 is **£16,644,570** for **235** transactions**.** Structured settlements relate to cases which have settled with a lower lump sum element within the total settlement value, plus annual payments over the lifetime of the claimant (the Periodical Payment Order). They typically relate to high value cases over £1M and are primarily used to meet the future care costs of the claimant as they fall due.

27. Right of Use / Finance leases obligations

27.1 Obligations (as lessee)

The Trust currently has finance lease obligations in respect of Buildings and Non-Property.

Amounts payable under right of use asset / finance leases:

LAND		Post Implementation of IFRS 16 (RoU) 31 March 2023 £000	Pre implementation of IFRS 16 (FL) 31 March 2022 £000	Post Implementation of IFRS 16 (RoU) 31 March 2023 £000	Pre implementation of IFRS 16 (FL) 31 March 2022 £000
		NHS Trust		Consolidated	
Minimum lease payments					
Within one year		**0**	0	**0**	0
Between one and five years		**0**	0	**0**	0
After five years		**0**	0	**0**	0
Less finance charges allocated to future periods		**0**	0	**0**	0
Minimum lease payments		**0**	0	**0**	0
Included in:	Current borrowings	**0**	0	**0**	0
	Non-current borrowings	**0**	0	**0**	0
Total		**0**	0	**0**	0
Present value of minimum lease payments					
Within one year		**0**	0	**0**	0
Between one and five years		**0**	0	**0**	0
After five years		**0**	0	**0**	0
Total present value of minimum lease payments		**0**	0	**0**	0
Included in:	Current borrowings	**0**	0	**0**	0
	Non-current borrowings	**0**	0	**0**	0
Total		**0**	0	**0**	0

27.1 Finance leases obligations (as lessee) continued

Amounts payable under right of use asset / finance leases: BUILDINGS	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022
Minimum lease payments	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Within one year	**963**	0	**963**	0
Between one and five years	**1,540**	0	**1,540**	0
After five years	**687**	0	**687**	0
Less finance charges allocated to future periods	**(105)**	0	**(105)**	0
Minimum lease payments	**3,085**	0	**3,085**	0
Included in: Current borrowings	**941**	0	**941**	0
Non-current borrowings	**2,144**	0	**2,144**	0
Total	**3,085**	0	**3,085**	0
Present value of minimum lease payments				
Within one year	**941**	0	**941**	0
Between one and five years	**1,491**	0	**1,491**	0
After five years	**653**	0	**653**	0
Total present value of minimum lease payments	**3,085**	0	**3,085**	0
Included in: Current borrowings	**941**	0	**941**	0
Non-current borrowings	**2,144**	0	**2,144**	0
Total	**3,085**	0	**3,085**	0

Amounts payable under right of use asset / finance leases: OTHER - Non Property	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022
Minimum lease payments	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Within one year	**185**	0	**185**	0
Between one and five years	**279**	0	**279**	0
After five years	**0**	0	**0**	0
Less finance charges allocated to future periods	**(6)**	0	**(6)**	0
Minimum lease payments	**458**	0	**458**	0
Included in: Current borrowings	**182**	0	**182**	0
Non-current borrowings	**276**	0	**276**	0
Total	**458**	0	**458**	0
Present value of minimum lease payments				
Within one year	**182**	0	**182**	0
Between one and five years	**276**	0	**276**	0
After five years	**0**	0	**0**	0
Total present value of minimum lease payments	**458**	0	**458**	0
Included in: Current borrowings	**182**	0	**182**	0
Non-current borrowings	**276**	0	**276**	0
Total	**458**	0	**458**	0

27.2 Right of Use Assets / Finance lease receivables (as lessor)

Amounts receivable under right of use assets / finance leases:

The Trust has no finance lease receivables.

Amounts receivable under right of use assets / finance leases:		Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)	Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
		31 March	31 March	**31 March**	31 March
		2023	2022	**2023**	2022
Gross investment in leases		**£000**	£000	**£000**	£000
		NHS Trust		**Consolidated**	
Within one year		**0**	0	**0**	0
Between one and five years		**0**	0	**0**	0
After five years		**0**	0	**0**	0
Less finance charges allocated to future periods		**0**	0	**0**	0
Present value of minimum lease payments		**0**	0	**0**	0
Included in:	Current borrowings	**0**	0	**0**	0
	Non-current borrowings	**0**	0	**0**	0
Total		**0**	0	**0**	0
Present value of minimum lease payments					
Within one year		**0**	0	**0**	0
Between one and five years		**0**	0	**0**	0
After five years		**0**	0	**0**	0
Less finance charges allocated to future periods		**0**	0	**0**	0
Total present value of minimum lease payments		**0**	0	**0**	0
Included in:	Current borrowings	**0**	0	**0**	0
	Non-current borrowings	**0**	0	**0**	0
Total		**0**	0	**0**	0

27.3 Finance Lease Commitment

The Trust does not have any commitments becoming operational in a future period.

28. Private finance transactions

Private Finance Initiatives (PFI) / Public Private Partnerships (PPP)

The Trust has no PFI or PPP Schemes.

29. Financial Risk Management

IFRS 7, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

NHS Trusts are not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. NHS Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing NHS Trusts in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk
The Trust's net operating costs are incurred under annual service agreements with various Health bodies, which are financed from resources voted annually by parliament. NHS Trusts also largely finance their capital expenditure from funds made available from the Welsh Government under agreed borrowing limits. NHS Trusts are not, therefore, exposed to significant liquidity risks.

Interest-rate risks
The great majority of NHS Trusts' financial assets and financial liabilities carry nil or fixed rates of interest. NHS Trusts are not, therefore, exposed to significant interest-rate risk.

Foreign currency risk
NHS Trusts have no significant foreign currency income or expenditure and any such risk for Velindre University NHS Trust is underwritten by Welsh Government.

Credit Risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures are in receivables from customers as disclosed in the trade and other receivables note.

General
The powers of the Trust to invest and borrow are limited. The Board has determined that in order to maximise income from cash balances held, any balance of cash which is not required will be invested. The Trust does not borrow from the private sector. All other financial instruments are held for the sole purpose of managing the cash flow of the Trust on a day to day basis or arise from the operating activities of the Trust. The management of risks around these financial instruments therefore relates primarily to the Trust's overall arrangements for managing risks to their financial position, rather than the Trust's treasury management procedures.

30. Movements in working capital

	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
Movements in working capital	NHS Trust		Consolidated	
(Increase) / decrease in inventories	**31,137**	30,357	**31,137**	30,357
(Increase) / decrease in trade and other receivables - non-current	**(15,039)**	(274,866)	**(15,039)**	(274,866)
(Increase) / decrease in trade and other receivables - current	**(67,264)**	8,609	**(68,355)**	9,383
Increase / (decrease) in trade and other payables - non-current	**(4,244)**	35	**(4,244)**	35
Increase / (decrease) in trade and other payables - current	**(9,598)**	(75,535)	**(11,122)**	(75,594)
Total	**(65,008)**	(311,400)	**(67,623)**	(310,685)
Adjustment for accrual movements in fixed assets - creditors	**(961)**	(2,415)	**(961)**	(2,415)
Adjustment for accrual movements in fixed assets - debtors	**0**	(187)	**0**	(187)
Other adjustments	**9,241**	(1,093)	**9,368**	(1,077)
Total	**(56,728)**	(315,095)	**(59,216)**	(314,364)

31. Other cash flow adjustments

	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	NHS Trust		Consolidated	
Other cash flow adjustments	£000	£000	£000	£000
Depreciation	**10,504**	9,110	**10,504**	9,110
Amortisation	**1,358**	1,112	**1,358**	1,112
(Gains)/Loss on Disposal	**(3)**	0	**(3)**	0
Impairments and reversals	**3,363**	0	**3,363**	0
Release of PFI deferred credits	**0**	0	**0**	0
NWSSP Covid assets issued debited to expenditure but non-cash	**0**	0	**0**	0
NWSSP Covid assets received credited to revenue but non-cash	**0**	0	**0**	0
Donated assets received credited to revenue but non-cash	**0**	0	**0**	0
Government Grant assets received credited to revenue but non-cash	**0**	0	**0**	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non ca	**0**		**0**	
Non-cash movements in provisions	**183,967**	443,268	**183,967**	443,268
Total	**199,189**	453,490	199,189	453,490

32. Events after reporting period

NHS Wales bodies were notified in a pay circular letter issued on 25th May 2023 by the Welsh Government, of the additional pay arrangements for employees covered by the Agenda for Change terms and conditions in Wales for 2022-23, which will be funded by the Welsh Government.
NHS Wales bodies will make a one off non-consolidated, prorated “recovery payment” for staff employed on the Agenda for Change terms and conditions (this includes most NHS staff including nursing staff but excludes medical staff).
These costs have not been recognised in the 2022-23 financial statements because the obligating event was the publication of the offer agreed with the Minister on 20 April 2023 and therefore post 31st March 2023. The costs will be accounted for in the 2023-24 Annual Accounts of NHS Wales bodies.
The estimated cost is £3.419m.

The detailed extent and condition of the NHS Wales organisations' buildings identified as having Reinforced Autoclaved Aerated Concrete (RAAC), has yet to be completed. Thus to make an informed assessment to determine the remaining life assessment of the buildings further work is required. This work is being undertaken at present across all of the NHS Estate (which will hopefully be completed by late summer 2023) which will enable such an assessment to be made for the 23-24 financial year.

During the financial year, it was identified that in order to progress with the building of the new Velindre Cancer Centre, a European Protected Species Licence is required to allow clearance of the site in early 2023/2024. To secure this licence, a portion of the neighbouring Cardiff and Vale UHB site is required to create around 1.6 hectares of new habitat. The Trust Board agreed on 28 April 2023 that the Trust should express an interest in the acquisition of the site.

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 01 Aug 2023; post the date the financial statements were certified by the Auditor General for Wales.

33. Related Party transactions

The Trust is a body corporate established by order of the Welsh Minister for Health and Social Services.

The Welsh Government is regarded as a related party. During the year, the Trust has had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely:

Related Party	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Welsh Government	34,670	302,408	8,812	1,632,351
WHSSC	600	53,062	164	(1,754)
Aneurin Bevan UHB	29,264	78,852	33,156	3,043
Betsi Cadwaladr UHB	39,389	53,808	30,160	3,494
Cardiff and Vale UHB	27,782	95,552	21,306	3,814
Cwm Taf Morgannwg UHB	36,166	63,239	16,445	(669)
Hywel Dda UHB	18,614	28,612	20,642	2,213
Powys THB	1,300	3,334	1,300	399
Swansea Bay UHB	20,093	51,982	21,270	2,440
Public Health Wales NHS Trust	446	8,686	944	1,150
Welsh Ambulance Service NHS Trust	3,061	2,275	2,334	689
Health Education & Improvement Wales	14	56,494	6	2,175
Digital Health & Care Wales	4,874	1,520	1,930	449
Welsh Risk Pool	0	45	0	57
Welsh Local Authorities (*excluding those listed below where declarations of interest have been received*):	1,388	26	87	26

Parties where specific interests have been declared	Name of individual declaring interest	Nature of the relationship				
Pembrokeshire County Council	Martin Veale, Independent Member	Lay Member of Audit Committee	(1)	0	8	0
Capita	Donna Mead, Chair	Party employs son	3	0	23	0
City Hospice	Stephen Harries, Vice Chair	Member	(3)	295	3	101
CTX-Cyf	Chief Operating Officer - Cath C	Partner is Company Director	(1)	0	0	0
Healthcare People Management Association	Sarah Morley, Executive Director of Organisational Development & Workforce	Joint President & Trustee	11	0	1	0
John Sisk	Gareth Jones, Independent Member	Senior Counsel	9	0	14	0
Life Sciences Hub	Cath O'Brien, Chief Operating Officer Neil Frow, NWSSP Accountable Officer	COB: Director NF: Observer at Board	0	0	4	0
			217,679	**800,190**	**158,609**	**1,649,978**

In addition, the Trust has had a number of material transactions with other Government departments and other central and local Government bodies. The majority of these transactions have been with universities; and other transactions include payments to English, Scottish and Irish NHS organisations amounting to £13,594,000 (2021/2022 £10,053,000); of this total £2,208,000 (2021/2022 £1,610,550) related to an English Trust that provides a lease car salary sacrifice scheme to Trust employees.

The Trust Board is the corporate trustee of Velindre University NHS Trust Charitable Funds. During the year the Trust received £1,343,000 (2021/2022 £2,791,000) from Velindre University NHS Trust Charitable Funds.

Welsh Government expenditure excludes £18,479,000 that relates to Public Dividend Capital (PDC) received during 2022/2023 (2021/2022 £9,486,000 was received).

Transactions with Capita, City Hospice, CTX-Cyf, Healthcare People Management Association, Life Sciences Hub and John Sisk have been disclosed due to senior Trust managers declaring an interest in these parties and as the transactions could be of material value to these companies.

34. Third party assets

The Trust held £nil cash at bank and in hand at 31 March 2023 (31 March 2022, £nil) which relates to monies held by the Trust on behalf of patients. Cash held in Patient's Investment Accounts amounted to £nil at 31 March 2023 (31 March 2022, £nil).

35. Pooled budgets

Velindre University NHS Trust has no pooled budgets.

36. Operating Segments

IFRS 8 requires organisations to report information about each of its operating segments.

36. Operating Segments	VELINDRE		NWSSP		WRP		TOTAL		FHOT		ELIMINATIONS		CONSOLIDATED	
	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22
Operating Revenue	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Segmental Income	183,449	171,601	572,881	444,770	201,411	427,428	957,741	1,043,799	4,781	3,066	(1,343)	(2,791)	961,179	1,044,074
	183,449	**171,601**	**572,881**	**444,770**	**201,411**	**427,428**	**957,741**	**1,043,799**	**4,781**	**3,066**	**(1,343)**	**(2,791)**	**961,179**	**1,044,074**
Operating Expenses	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Local Health Boards	243	250	14,241	11,214	0	0	14,484	11,464	0	0	0	0	14,484	11,464
Welsh NHS Trusts	0	0	18	23	0	0	18	23	0	0	0	0	18	23
Welsh Special Health Authorities	451	10	1,570	1,160	0	0	2,021	1,170	0	0	0	0	2,021	1,170
Goods and services from other NHS bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WHSSC & EASC	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Local Authorities	3	0	0	0	0	0	3	0	0	0	0	0	3	0
Purchase of healthcare from non-NHS bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Welsh Government	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other NHS Trusts	0	0	508	514	0	0	508	514	0	0	0	0	508	514
Directors' costs	1,420	1,392	0	0	0	0	1,420	1,392	0	0	0	0	1,420	1,392
Operational staff costs	80,121	72,919	91,225	81,063	0	0	171,346	153,982	0	0	0	0	171,346	153,982
Non operational trainee staff costs	0	0	229,121	137,379	0	0	229,121	137,379	0	0	0	0	229,121	137,379
Non operational collaborative bank staff costs	0	0	347	234	0	0	347	234	0	0	0	0	347	234
Single lead employer staff trainee costs	2,743	1,033	0	0	0	0	2,743	1,033	0	0	0	0	2,743	1,033
Collaborative bank staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies and services - clinical	80,909	77,334	64,083	58,840	0	0	144,992	136,174	0	0	0	0	144,992	136,174
Supplies and services - general	657	292	82,683	77,755	0	0	83,340	78,047	0	0	0	0	83,340	78,047
Consultancy Services	2,403	841	1,547	3,383	0	0	3,950	4,224	0	0	0	0	3,950	4,224
Establishment	2,777	3,053	10,429	9,330	0	0	13,206	12,383	0	0	0	0	13,206	12,383
Transport	953	811	2,530	2,349	0	0	3,483	3,160	0	0	0	0	3,483	3,160
Premises	5,908	5,891	23,954	18,880	0	0	29,862	24,771	0	0	0	0	29,862	24,771
FHOT Resources expended:														
Costs of generating funds	0	0	0	0	0	0	0	0	965	362	(311)	(205)	654	157
Charitable activites	0	0	0	0	0	0	0	0	1,110	2,206	(932)	(2,512)	178	(306)
Governance Costs	0	0	0	0	0	0	0	0	83	59	(100)	(74)	(17)	(15)
Impairments and Reversals of Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation	5,469	5,987	3,357	3,123	0	0	8,826	9,110	0	0	0	0	8,826	9,110
Depreciation (RoU Asset)	148		1,529		0		1,677		0		0		1,677	
Amortisation	787	680	571	432	0	0	1,358	1,112	0	0	0	0	1,358	1,112
Impairments and reversals of property, plant and equipment	0	0	1,121	0	0	0	1,121	0	0	0	0	0	1,121	0
Fixed asset impairments and reversals (RoU Assets)	0		1,894		0		1,894		0		0		1,894	
Impairments and reversals of intangible assets	0	0	348	0	0	0	348	0	0	0	0	0	348	0
Impairments and reversals of financial assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Impairments and reversals of non current assets held for sale	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Audit fees	236	224	7	0	0	0	243	224	17	15	0	0	260	239
Other auditors' remuneration	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Losses, special payments and irrecoverable debts	(1,084)	472	19,659	21,082	209,408	426,335	227,983	447,889	0	0	0	0	227,983	447,889
Research and development	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NWSSP centrally purchased and donated COVID items issued free of charge to NHS Wales organisations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NWSSP centrally purchased COVID items issued free of charge to other organisations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expense related to short-term leases	197		172		0		369		0		0		369	
Expense related to low-value asset leases (excluding short-term leases)	40		20		0		60		0		0		60	
Other operating expenses	256	408	21,903	18,242	963	0	23,122	18,650	0	0	0	0	23,122	18,650
Total	**184,637**	**171,597**	**572,837**	**445,003**	**210,371**	**426,335**	**967,845**	**1,042,935**	**2,175**	**2,642**	**(1,343)**	**(2,791)**	**968,677**	**1,042,786**
Investment Revenue	1,257	23	0	0	0	0	1,257	23	144	114	0	0	1,401	137
Other Gains and Losses	0	3	3	0	0	0	3	3	0	0	0	0	3	3
Finance Costs	(4)	0	(36)	0	8,960	(1,093)	8,920	(1,093)	0	0	0	0	8,920	(1,093)
SURPLUS / (DEFICIT) *(excluding donated assets received or issued)*	**65**	**30**	**11**	**(233)**	**0**	**0**	**76**	**(203)**	**2,750**	**538**	**0**	**0**	**2,826**	**335**

37. Other Information

37.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2022 to 31 March 2023. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2022 and February 2023 alongside Trust data for March 2023.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2022-23	2021-22
STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2023	**£000**	**£000**
Revenue from patient care activities	14,659	11,406
Operating expenses	14,659	11,406
3. Analysis of gross operating costs		
3. Revenue from patient care activities		
Welsh Government	3,373	3,160
Welsh Government - Hosted Bodies	3,868	3,535
4. Other Operating Revenue		
Other	7,418	4,711
5.1 Operating expenses		
Directors' costs	59	58
Operational staff costs	7,182	6,604
Non operational trainee staff costs	7,328	4,704
Non operational collaborative bank staff costs	9	7
Single lead employer staff trainee cost	81	33
Collaborative bank staff cost	0	0

Notional income reported as 'other operating revenue' is from Local Health Boards, Welsh NHS Trusts and Welsh Special Health Authorities in respect of the Single Lead Employer (SLE) trainees employed via NWSSP and operational within the respective organisation.

37. Other Information (continued)

37.2 Other (continued)

Welsh Government Covid 19 Funding

Details of Covid 19 Pandemic Welsh Government funding amounts provided to the Trust:

	NWSSP 2022-23 £000	Velindre 2022-23 £000	Total 2022-23 £000	Total 2021-22 £000
Capital				
Capital Funding Field Hospitals				0
Capital Funding Equipment & Works				675
Capital Funding other (Specify)				0
Welsh Government Covid 19 Capital Funding	**-**	**-**	**-**	**675**
Revenue				
Stability Funding	4,580	575	**5,155**	**7,406**
Covid Recovery	0	0	**0**	3,479
Cleaning Standards	0	0	**0**	769
PPE (including All Wales Equipment via NWSSP)	25,850	70	**25,920**	47,180
Testing / TTP- Testing & Sampling - Pay & Non Pay	0	0	**0**	3,941
Tracing / TTP - NHS & LA Tracing - Pay & Non Pay	0	0	**0**	0
Extended Flu Vaccination / Vaccination - Extended Flu Programme	0	0	**0**	0
Mass Covid-19 Vaccination / Vaccination - COVID-19	1,337	224	**1,561**	1,853
Annual Leave Accrual - Increase due to Covid				0
Urgent & Emergency Care				77
Private Providers Adult Care / Support for Adult Social Care Providers				0
Hospices				4,500
Other Mental Health / Mental Health				0
Other Primary Care	0	0	**0**	0
Social Care				0
Dental Patient charges				0
Nosocomial C19 Funding	0	4	**4**	0
Other	0	0	**0**	0
Welsh Government Covid 19 Revenue Funding	**31,767**	**873**	**32,640**	**69,205**

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

NHS TRUSTS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2010 and subsequent financial years in respect of the NHS Wales Trusts in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the NHS Wales Trusts shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year for which the accounts are being prepared, as detailed in the NHS Wales Trust Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the Trust for the year ended 31 March 2010 and subsequent years shall comprise a foreword, an income statement, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied to the NHS Wales Manual for Accounts, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2010 and subsequent years, the account of the Trust shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated : 17.06.2010

1 Please see regulation 3 of the 2009 No 1558(W.153); NATIONAL HEALTH SERVICE, WALES; The National Health Service Trusts (Transfer of Staff, Property Rights and Liabilities)

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CF15 7QZ

Ffôn/Phone : (029) 20196161
https://velindre.nhs.wales

Final Letter of Representation

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

27 July 2023

Representations regarding the 2022-23 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Velindre University NHS Trust for the year ended 31st March 2023 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- Preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers/HM Treasury, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Velindre University NHS Trust will continue in operation.

- Ensuring the regularity of any expenditure and other transactions incurred.

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Gwasanaeth Gwaed Cymru Welsh Blood Service

Canolfan Ganser Felindre Velindre Cancer Centre

Pencadlys Ymddiriedolaeth GIG Prifysgol Felindre
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- The design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
- unrestricted access to staff from whom you determined it necessary to obtain audit evidence.

- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

- Our knowledge of fraud or suspected fraud that we are aware of and that affects Velindre University NHS Trust and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.
- Our knowledge of all possible and actual instances of irregular transactions.

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Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by the Board of Velindre University NHS Trust

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Board on 27th July 2023.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by: Chief Executive	Signed by: Chair of the Trust
Date:	Date:

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16 March 2023

Dear Matt,

Audit enquiries to those charged with governance and management

The Auditor General's Statement of Responsibilities sets out that he is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. It also sets out the respective responsibilities of auditors, management and those charged with governance.

This letter formally seeks documented consideration and understanding on a number of governance areas that impact on our audit of your financial statements. These considerations are relevant to both the management of Velindre University NHS Trust (the Trust) and 'those charged with governance' (the Board).

I have set out below the areas of governance on which I am seeking your views:

1. Matters in relation to fraud
2. Matters in relation to laws and regulations
3. Matters in relation to related parties

The information you provide will inform our understanding of the Trust and its business processes and support our work in providing an audit opinion on your 2022-23 financial statements.

I would be grateful if you could update the attached table in Appendix 1 to Appendix 3 for 2022-23.

The completed Appendix 1 to Appendix 3 should be formally considered and communicated to us on behalf of both management and those charged with governance by **5 May 2023**. In the meantime, if you have queries, please contact me (02920 320664 or at steve.wyndham@audit.wales).

Yours sincerely

Steve Wyndham

Audit Manager

Cc

Richard Harries, Audit Wales Engagement Lead

Clare Bowden, Head of Financial Operations

Appendix 1

Matters in relation to fraud

International Standard for Auditing (UK) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements. This standard has been revised for 2022-23 audits.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for Velindre University NHS Trust (the Trust) is the Board. Management, with the oversight of those charged with governance, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- The intentional misappropriation of assets (cash, property, etc); or
- The intentional manipulation or misstatement of the financial statements.

We also need to understand how those charged with governance exercises oversight of management's processes. We are also required to make enquiries of both management and those charged with governance as to their knowledge of any actual, suspected or alleged fraud, management's process for identifying and responding to the risks and the internal controls established to mitigate them.

Enquiries of management – in relation to fraud

Question	2022-23 Response
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud? What is the nature, extent and frequency of management's assessment?	The Trust's Standing Financial Instructions are designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business: they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders, a Schedule of decisions reserved to the Board and a Scheme of delegation to officers and others, they provide the regulatory framework for the business conduct of the Trust. This regulatory framework, together with detailed and regular financial reporting throughout the year significantly mitigates the risk of the financial statements being materially misstated due to fraud. This risk is further mitigated by issuing clear guidance and instructions to management and budgetary holders regarding their financial management responsibilities. Management's assessment of this risk is therefore that it is currently rated as low.
2. Do you have knowledge of any actual, suspected or alleged fraud affecting the audited body?	Yes - as part of their meetings, the Audit Committee receives a Counter Fraud Progress Report which includes relevant reference to any new cases, significant changes with ongoing investigations, together with outcomes from cases that are already in the public domain. Management representatives attend the Audit Committee and so have access to this information.

Enquiries of management – in relation to fraud

Question	2022-23 Response
3. What is management's process for identifying and responding to the risks of fraud in the audited body, including any specific risks of fraud that management has identified or that have been brought to its attention?	The risks around fraud are mitigated by a robust and well-resourced counter fraud programme. This programme is led and resourced by a dedicated local Counter Fraud Team. The Cabinet Office NHS requirement gov13 requires that the counter fraud risk assessment is carried out by the Counter Fraud Team. All informed Fraud Risk is subject to assessment and review by the counter fraud team. This can be informed internally via management, post-investigation, thematic exercise or central NHS trends. Thorough assessment is conducted and recommendations made which are reported to Directorate, Executive Director with responsibility for the risk domain, Executive Director of Finance and Audit committee. The aim of the assessment is to fraud proof areas, address any identified weakness and with the goal of reducing the opportunity of fraud to an absolute minimum. All fraud risks remain live on a living document within the Counter Fraud department and are subject to regular review. All fraud risk is recorded and reported to the NHS CFA via the CLUE case management system. All fraud risk work carried out is compliant with the organisations over riding Risk Management Policy and the requirements of Compliance set by the NHS CFA. The Trust has in place a Counter Fraud Policy which is intended to provide direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and

Enquiries of management – in relation to fraud

Question	2022-23 Response
	information on various aspects and implications of an investigation. The Policy was reviewed & updated earlier this year. The fundamental financial systems are robustly reviewed by internal audit on a cyclical basis to test that they are being used appropriately and that adequate controls are in place. The Trust has other policies and resources that would support it in identifying and reporting risks, such as: • various incident reporting routes • Incident Reporting Policy • Raising Concerns (Whistle blowing Policy) In addition, a series of Counter Fraud awareness events are held by the Local Counter Fraud Team, on behalf of the Trust, which staff are encouraged to attend. A short summary of the Counter Fraud strategy and contact details are also available on the Trust intranet pages, that signposts to a comprehensive dedicated Counter Fraud Intranet site which contains a high volume of support material. A bi-monthly newsletter from the Counter Fraud team is shared periodically with Trust staff.
4. What classes of transactions, account balances and disclosures have you identified as most at risk of fraud?	Payments to staff & suppliers: particularly those that are marked 'urgent' or are made to bank accounts that have not previously received payments from the Trust.

Enquiries of management – in relation to fraud

Question	2022-23 Response
5. Are you aware of any whistleblowing or complaints by potential whistle blowers? If so, what has been the audited body's response?	All complaints made in relation to fraud are directed to the local Counter Fraud team via the reporting routes available. These can be anonymous or named. There have been a number of complaints/referrals this year and the response is always consistent. Whistleblowers are treated in accordance with policy and identity is protected where appropriate. All reports of fraud are robustly investigated and each is dealt with on its own merits once the investigation is complete. Should there be the need for follow up with regard to identified risk then this is carried out accordingly.
6. What is management's communication, if any, to those charged with governance regarding their processes for identifying and responding to risks of fraud?	The Trust's Counter Fraud Policy as described in question (3) above provides direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and information on various aspects and implications of an investigation. The Trust's Standards of Behaviour Framework Policy outlines how the Trust is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported in delivering those requirements.

Enquiries of management – in relation to fraud

Question	2022-23 Response
	There is also a dedicated webpage supporting this policy including Frequently Asked Questions, guidance documents, and contact details for support on the Trust's intranet pages. It is a requirement that annual declaration of interests are obtained from specific groups of employees and Independent Members, and this is completed in March each year. All fraud risks that are identified are duly reported to the risk owning domain and for assurance purposes and monitoring via the Audit Committee.
7. What is management's communication, if any, to employees regarding their views on business practices and ethical behaviour?	The response to question (6) above is equally relevant here. In addition, regular Annual Performance Appraisals and Development Reviews undertaken support and reinforce the code of conduct and performance expected from Trust employees.
8. For service organisations, have you reported any fraud to the user entity?	No fraud reported to a user entity. Should matters arise that concerns other agencies or partners then a close working protocol is adopted in order that all fraud identified is appropriately dealt with. Eg: Overseas Patients and Immigration Services; Taxi Contracts; Universities; nursing agencies. Should fraud occur in a partner organisation and the Trust is not the victim then assistance is provided to the investigating body.

Enquiries of those charged with governance – in relation to fraud

Question	2022-23 Response
1. Do you have any knowledge of actual, suspected or alleged fraud affecting the audited body?	Yes - as part of their meetings, the Audit Committee receives a Counter Fraud Progress Report which includes relevant reference to any new cases, significant changes with ongoing investigations, together with outcomes from cases that are already in the public domain.
2. What is your assessment of the risk of fraud within the audited body, including those risks that are specific to the audited body's business sector?	The risk of fraud occurring within the organisation is always present. However, a robust and planned Fraud Risk Assessment programme is undertaken by the Counter Fraud Team and the aim of this is to reduce the risk of fraud to an absolute minimum. The fraud risk management programme is fully compliant with the local Risk Management Policy and the Cabinet Office Gov 13 NHS Requirements in relation to risk management. All fraud risk work is reported through audit committee and to the Counter Fraud Authority quality and compliance team via an end of year functional standard return. Inherent risks are identified and assessed and any newly identified risks are added to this living document.

Enquiries of those charged with governance – in relation to fraud

Question	2022-23 Response
3. How do you exercise oversight of: • management's processes for identifying and responding to the risk of fraud in the audited body, and • the controls that management has established to mitigate these risks?	Audit reports provide the Audit Committee with assurance as to whether appropriate control measures are in place and whether the Trust is compliant with current standard practice. The Audit Committee provide a highlight report to each Trust Board meeting to provide assurance and inform them of any issues. All fraud risks are recorded on the clue case management system by the counter fraud manager. They are retained as a live document and are subject to review on a timed basis. Recommendations made as a result of risk assessment is subject to onward testing by way of Local Proactive Exercise.

Appendix 2

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, is responsible for ensuring that the Trust's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements;
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures we are required to make enquiries of management and those charged with governance as to whether the Trust is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

Enquiries of management – in relation to laws and regulations

Question	2022-23 Response
1. Is the audited body in compliance with relevant laws and regulations? How have you gained assurance that all relevant laws and regulations have been complied with? Are there any policies or procedures in place?	The Trust is compliant with relevant laws and regulations. Employees and Senior Officers within the Finance and Information Governance Function are professionally qualified and experienced and are required as part of their role within the Trust to ensure that they remain aware of any legislative or regulatory changes. All Wales groups such as the Directors of Finance Forum, Deputy Directors of Finance Forum, and the All Wales Technical Accounting Group help facilitate this shared learning. Cyclical audits on systems and processes applied in the Trust are reviewed in light of expected current practice and would highlight any breaches or compliance issues in respect of current legislation and/or regulation. Also, the Trust compiles a Legislative & Regulatory Compliance Register which is presented to the Audit Committee on a regular basis. The purpose of the register is to ensure the Trust has a comprehensive and up-to-date list of the legislation that applies to it. It is also a mechanism which demonstrates that the Trust can ensure that by regular updating and monitoring of the register there is a process in place that ensures compliance with legislation is being managed effectively.
2. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations in the financial year, or earlier with an	During the final quarter of 2020/2021, liaison with VAT advisors identified potential non-compliance in one area. A provision was made within the 2020/21 financial statements which has been

Enquiries of management – in relation to laws and regulations

Question	2022-23 Response
ongoing impact on this year's audited financial statements?	reviewed, updated, and is reflected in the 2022/2023 financial statements.
3. Are there any potential litigations or claims that would affect the financial statements?	The Director of Finance and the Head of Financial Operations monitor and are not aware of any litigation claims against the Trust which could impact the financial statements. Losses and Redress reports detailing claims are received at relevant Trust Committees. In respect of civil litigation claims against the Trust, quantum values of each case are provided and based on the probability of success, the Trust accrues the relevant cost against each case as appropriate. This ensures that the quantum value assigned to each case is monitored and reported within the financial accounts.
4. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	There have not been any reports from regulatory bodies indicating non compliance. To note, a HMRC review of the Trust's treatment of VAT and employment taxes which commenced in 2017/2018 concluded in 2022/2023 with no further issues of non compliance noted.
5. Are you aware of any non-compliance with laws and regulations within service organisations since 1 April of the	A Data Processor under contract to the Trust did not comply with UK GDPR Article 28(2) and (3)(a) in that it failed to:

Enquiries of management – in relation to laws and regulations

Question	2022-23 Response
financial year? This would include the NHS Wales Shared Services Partnership.	1. Comply with Article 28(3)(a) UK GDPR in that it processed personal data against the express instructions of the Controller by 2. Appointing a sub-processor without the express permission of the controller which contravened Article 28(2) UK GDPR and that the Processor directed the Sub-Processor to destroy Trust records against the express instructions of the controller The Information Commissioner was informed, a full investigation was carried out and the Trust found to have acted appropriately. Full details are in the 2022/23 IG Disclosure Statement with findings.

Enquiries of those charged with governance – in relation to laws and regulations

Question	2022-23 Response
1. Are you aware of any non-compliance with laws and regulations that may be expected to have a fundamental effect on the operations of the entity?	The Board is not aware of any non-compliance issues in relation to relevant laws and regulations that have had a fundamental effect on the operations of the entity. Any such incidents would be reported to the Board via the Audit Committee if they occurred as happens in instances of non-compliance with for example, Standing Orders (SOs) or Standing Financial Instructions (SFIs). However, Internal Audit recommendations in their audit of nVCC MIM Contract Management identified non-compliances with the SOs & SFIs regarding the procurement of advisors and the approval of contract value increases for the new Velindre Cancer Centre (nVCC): • Undertaking a lessons-learned exercise on contract management practices applied to date for nVCC; • Developing a governance framework for effective and compliant management of advisor and construction contracts at the nVCC and Enabling Works projects; and • Delegation to a suitable level (e.g., Chief Executive) of a contingency allowance (accommodated within the project budget) for the management of compensating events where NEC contracts are applied. The Trust is in the process of implementing the agreed management actions in response to the recommendations.

Enquiries of those charged with governance – in relation to laws and regulations	
Question	**2022-23 Response**
2. How does the Board, in your role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	Audit reports provide the Audit Committee with assurance as to whether appropriate control measures are in place and whether the Trust is compliant with current standard practice. The Audit Committee provide a highlight report to each Trust Board meeting to provide assurance and inform them of any issues.

Appendix 3

Matters in relation to related parties

International Standard for Auditing (UK) 550 covers auditors' responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Enquiries of management – in relation to related parties

Question	2022-23 Response
1. Have there been any changes to related parties from the prior year? If so, what is the identity of the related parties and the nature of those relationships? Confirm these have been disclosed to the auditor.	Annual declaration of interests are obtained from specific groups of Employees and Independent Members to confirm if there are any changes required to related parties from the prior year. The annual updated declarations of interest for the reporting period have been provided to the Trust Finance Team for their review and action as appropriate and reporting in regards to any matters pertinent to the Trust Annual Accounts for the respective reporting period.
2. What transactions have been entered into with related parties during the period? What is the purpose of these transactions? Confirm these have been disclosed to the auditor.	The total value of any transactions with related parties are calculated and reported in the related party note (number 33) in the Trust's accounts. Details of these transactions will be available to the Audit team during the audit of the accounts.

Enquiries of management – in relation to related parties

Question	2022-23 Response
3. What controls are in place to identify, account for and disclose related party transactions and relationships?	Statements are included in the Statement of Accounts acknowledging the relationships. These statements are produced by experienced and qualified officers with an in-depth knowledge of Trust operations. Audit reviews are undertaken to ensure appropriate control measures are in place. Annual declaration of interests are obtained from specific groups of Employees and Independent Members. Access is provided to the Trust to examine Welsh Ministers interest delegations.
4. What controls are in place to authorise and approve significant transactions and arrangements: • with related parties, and • outside the normal course of business?	The NWSSP Procurement team manage all such arrangements in line with the Trust Standing Financial Instructions, NWSSP Procurement manual and detailed policies and procedures. Any non compliance or matters of note are reported to the Audit Committee.

Enquiries of those charged with governance – in relation to related parties

Question	2022-23 Response
1. How does the Board, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?	The Audit Committee receives the Statement of Accounts and receives assurance from Senior Officers and through audit mechanisms that they are accurate. The Audit Committee are able to scrutinise, challenge and query any aspect of the accounts and request further supporting information or initiate any additional work to assure themselves this area is addressed. Any relevant issues are subsequently reported to the Board.

Archwilio Cymru
Audit Wales

Audit of Accounts Report
Velindre University NHS Trust

Audit year: 2022-23

Date issued: July 2023

Document reference: 3701A2023

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

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

Contents

We intend to issue an unqualified audit report on your Accounts. There are some issues to report to you prior to their approval.

Audit of Accounts Report

Appendices

Audit of Accounts Report

Introduction

1 We summarise the main findings from our audit of your 2022-23 annual report and accounts in this report.

2 We have already discussed these issues with the Executive Director of Finance and senior finance colleagues.

3 Auditors can never give complete assurance that accounts are correctly stated. Instead, we work to a level of 'materiality'. This level of materiality is set to try to identify and correct misstatements that might otherwise cause a user of the accounts into being misled.

4 We set this level at £9.7 million for this year's audit.

5 There are some areas of the accounts that may be of more importance to the reader and we have set a lower materiality level for these, as follows:

- Remuneration report / senior pay disclosure - £5,000; and
- Related parties - £10,000 for individuals interests.

6 We have now substantially completed this year's audit but the following work is outstanding:

- The review of the revised financial statements and Annual Report;
- Obtaining responses to some outstanding document requests in regard to our IT audit work; and
- The completion of our internal file review arrangements.

7 In our professional view, we have complied with the ethical standards that apply to our work; remain independent of yourselves; and our objectivity has not been compromised in any way. There are no relationships between ourselves and yourselves that we believe could undermine our objectivity and independence.

8 The timeline of the audit is set out in **Exhibit 1** below:

Exhibit 1 – audit timetable

Timetable	• We received the draft accounts on 5 May 2023 • Our deadline for completing our audit has been extended to 31 July 2023 • We expect your audit report to be signed by the Auditor General on 31 July 2023

Proposed audit opinion

9 We intend to issue an unqualified audit opinion on this year's accounts once you have provided us with a Letter of Representation based on that set out in **Appendix 1**.

10 We issue a 'qualified' audit opinion where we have material concerns about some aspects of your accounts; otherwise we issue an unqualified opinion.

11 The Letter of Representation contains certain confirmations we are required to obtain from you under auditing standards.

12 Our proposed audit report is set out in **Appendix 2**.

Significant issues arising from the audit

Uncorrected misstatements

13 There are no misstatements identified in the accounts, which remain uncorrected.

Corrected misstatements

14 As a result of our audit there have been a number of adjustments to the financial statements. These adjustments are summarised, for information, in **Appendix 3**.

Other significant issues arising from the audit

15 In the course of the audit, we consider a number of other matters relating to the accounts, including any qualitative issues, and report any significant issues arising to you.

16 There is one issue to report concerning the difficulties we have experienced obtaining timely responses to clear some audit queries which has delayed the completion of our audit. A major issue impacting on this has been the staffing capacity within the Trust's finance team to support the audit process. The planned secondment to Welsh Government (from the start of June) of the Head of Financial Operations and the unforeseen sickness absence of her replacement had a significant contribution to this.

Recommendations

17 We will be reporting a number of recommendations in a separate report to the Trust which will be presented to a future Audit Committee. None of these recommendations are considered of to be sufficiently significant to necessitate reporting at this time.

Appendix 1

Final Letter of Representation

Audited body's letterhead

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Representations regarding the 2022-23 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Velindre University NHS Trust for the year ended 31st March 2023 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- Preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers/HM Treasury, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Velindre University NHS Trust will continue in operation.
- Ensuring the regularity of any expenditure and other transactions incurred.

- The design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects Velindre University NHS Trust and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.
- Our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by the Board of Velindre University NHS Trust

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Board on 27th July 2023.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Chief Executive	Chair of the Trust
Date:	Date:

Appendix 2

Proposed Audit Report

The Certificate and report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Velindre University NHS Trust and its group for the year ended 31st March 2023 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows and the Statement of Changes in Taxpayers' Equity and related notes, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Velindre University NHS Trust and its group as at 31st March 2023 and of its surplus for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the trust in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Velindre University NHS Trust is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent

with the financial statements and in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report or the Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records;
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and
- assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Trust will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the audited entity's internal auditors and those charged with governance, including obtaining and reviewing supporting documentation relating to Velindre University NHS Trust's policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud;
- Obtaining an understanding of Velindre University NHS Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Velindre University NHS Trust; and
- Obtaining an understanding of related party relationships

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether

the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of Velindre University NHS Trust's controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
31 July 2023

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Appendix 3

Summary of Corrections Made

Following our audit some adjustments have been made to the Financial Statements. These have been corrected by management. A summary of the most significant corrections made are summarised below.

Exhibit 2: summary of corrections made

Value of correction	Nature of correction
£14.587m	**Welsh Risk Pool Provisions** Reduction in the Welsh Risk Pool Provisions and corresponding debtor due from the Welsh Government due to the duplication of a case that became a Structured Settlement case in the year
£7.090m	**Property Plant and Equipment (Note 13)** There has been an increase in the closing Net Book Value of the Trust's property plant and equipment as a result of the correction of a validation error raised by the Welsh Government.
Various	**Reclassifications – NHS income and expenditure** Reclassification of NHS income and expenditure to provide an analysis in Notes 3, 4 and 5 that is consistent with the prior year and in line with the requirements of the Welsh Government.
Various	**Remuneration Report** Corrections have been made to the disclosures to ensure compliance with the Manual for Accounts. These include correcting the median pay disclosure and the remuneration bandings of several individuals.
£3.852m	**Trade & Other Payables (Note 20)** A classification error between Tangible and Intangible capital payables has been corrected.

Value of correction	Nature of correction
Narrative only	**Related Party Transactions (Note 33)** A small number of additional and revised disclosures have been made concerning transactions between the Trust and other bodies. This includes some bodies that individuals have declared an interest with that were not disclosed in the original draft accounts.
Various	**Cashflow Statement** Updating of the template accounts to ensure only cash movements are included.
Reclassification and narrative amendment	**Lease disclosures (Note 9)** Adjustments have made to the disclosure note to correctly reflect the Trust's lease liabilities.
Narrative only	**Note 32 - Events after the balance sheet date** Narrative included to disclose the value of the non-consolidated recovery payments made to the Trust's employees.
Narrative and presentational amendments	**Various** A number of other narrative and presentational amendments were made to supporting notes throughout the final financial statements and the annual report.

Audit Wales

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

AUDIT COMMITTEE

AUDIT WALES – AUDIT OF ACCOUNTS (ISA 260) REPORT

DATE OF MEETING	26/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris, Head of Financial Planning & Reporting
PRESENTED BY	Steve Wyndham, Financial Audit Manager, Audit Wales
EXECUTIVE SPONSOR APPROVED	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**

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Audit Wales' Audit of Accounts Report at July 2023 is attached for the Committee's information.

1.2 The Committee is asked to REVIEW and ENDORSE for Board approval the Wales Audit Report which provides an opinion of the financial statements for 2022-23.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The report has been prepared as part of Audit Wales work undertaken in accordance with statutory functions.

2.2 In the report, Audit Wales describe their intention to issue an unqualified true and fair audit opinion on the Trust's accounts for the year ended 2022/2023.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 The Committee are asked to REVIEW and ENDORSE for approval by the Trust Board on the 27th July 2023.

AUDIT COMMITTEE

Private Patient Service Improvements

DATE OF MEETING	26th July 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	17/05/2023	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 May 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 February 2023 and May 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. This role could potentially extend beyond the tenure and scope of the current agreement in the form of retained services for strategic and operational support. • 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 August 2023 to ensure actions are delivered, this remains within the financial limits approved by Velindre UNHS Trust. • Due to critical absences within the Finance Team and Private Patient Services Team, there has been unfortunate delays to the implementing the improvement plan, necessitating an extension to key deadlines and contracted support. • The External Private Patient experts Liaison Financials commenced supporting the Trust from the 3rd December 2022, with extension made to the end of August 2023 to support the delivery of agreed actions, due to the aforementioned critical absences and vacancies. • 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 revised identified

timescale with focus on contract negotiations, i.e. all those that link to Improvement action 17: 'Renegotiate the contracts with insurers' and supporting the recovery of the aged debt profile. Liaison have advised that all the preparatory work is being progressed for wider contract negotiations, with present commercial success of **£487k** likely retrospective income generation and **£558k** prospective additional income per annum.

- In addition to the financial benefits of contracting with Liaison, operational governance and processing issues have also been rectified, including updated policies, contracts, billing procedures, databases, insight and analysis.

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

  - Renegotiate the contracts with insurers – ***Liaison commenced review of current contracts. Target completion date of 31/08/2023 for the preparation work of reviewing current contract tariffs and negotiation 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.***
  - Developed 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.
  - Increased private income through exploiting opportunities to expand the clinical scope of the private patient service, as highlighted by the potential retrospective and prospective additional income streams.
  - 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, yielding the aforementioned additional income streams.
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. Due to critical staff absences, work had stalled though May and June periods, refocused from July onwards. • A Project Manager and admin support is being provided to the private patient project. • The aged debt profile and risk had been reduced significantly in comparison to the baseline audit reference period, however, Private Patient Services Team vacancies and maternity has resulted in return to former levels temporarily, 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 February and May 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: 17/05/2023

Ref No.	Status	Date	Recommendation/Issue to be addressed	Action Progress	Action Owner	Target Date	Revised Target Date	Outcome
STRATEGIC BUSINESS MANAGEMENT								
PP17	**IN PROGRESS**	28.01.22	Renegotiate the contracts with large insurers	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December 2022. 21/12/2022 - Target date revised to reflect discusions with Liaison Services who are supporting the renegotiation. A target of 31/03/2023 will remain for the preparation work of reviewing current contracts, tarrifs and ensuring Trust billing is up to date. DPIA's will be completed. 18/04/23 - Finance and LIAISON working together on financial resoruce mapping **17/05/23 - Work ongoing but may stall without DO.**	COB/MB / External Provider	30/09/2022	31/08/2023	
PP20	**IN PROGRESS**	28.01.22	Develop new professional fee arrangements which provide consistency across disciplines. Set fees at commercial levels.	21/11/2022 - Tarrif will be updated in line with contract discussions as in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - Finance and LIAISON working together on financial resource mapping **17/05/23 - Work ongoing but may stall without DO.**	External provider	31/07/2022	31/08/2023	
MEDICAL GOVERNANCE								
COMMERCIAL								
PP21	**IN PROGRESS**	28.01.22	Develop a private patient tariff for both self-pay and insured private patients	21/11/2022 - Refer to narrative in PP17. 22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial **and operating actions via prioritised plan.** **17/05/23 - Work ongoing but may be disrupted by BI resource issues.**	External provider	31/07/2022	31/08/2023	
PP22	**IN PROGRESS**	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	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	External provider	31/07/2022	31/08/2023	
PP25	**IN PROGRESS**	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	External provider **17/05/23 - Work ongoing but may be disrupted by BI resource issues.**	External provider	31/07/2022	31/08/2023	
OPERATIONAL								
PP43	**IN PROGRESS**	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 .22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan. 18/04/23 - HCaH contract reviewed and maximised for Blood Testing, but not the wider Chemo service - all contract negotiations aligned to Q1 delivery. **17/05/23 - Issues to be worked up when DO returns**	PW	31/07/2022	31/08/2023	
PP44	**IN PROGRESS**	07.06.23	To produce an output summary report at the conclusion of work conducted with the Trust, planned at Aug 23.	Liaison agreed to construction of output summary report	External Provider	31/08/2023		

Ref No	Service	Source	Issue	Outcomes Required	Suggested SMART Actions	Operational Lead	Executive Lead	Oversight	Evidence of Delivery	Delivery Date	Summary of Progress	RAG	Outstanding management Action
Strategic Business Management													
PP1	**IN PROGRESS**	28.01.22	Review and update Private Patient Service Specification	21/11/22 - Draft Policy circulated to Improvement Group members on 12th and 19th November 2022. Awaiting feedback. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		Head of Operational Services and Delivery				31/03/2023			
PP16	**IN PROGRESS**	28.01.22	Develop marketing plan/commercial 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.**		COB/MB / External Provider				31/03/2023			
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.	Links to Strategy. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		External provider				31/03/2023			
PP26	**IN PROGRESS**	28.01.22	Develop and implement a marketing plan and processes for both traditional and on-line digital	This will follow the agreement of a Strategy.						31/03/2023			
PP17	**IN PROGRESS**	28.01.22	Renegotiate the contracts with large insurers	21/11/2022- This is the first priority of the procured support. All contracts have been shared with them prior to their visit on 5th December 2022.		COB/MB / External Provider				30/06/2023			
Medical Governance													
PP7	**IN PROGRESS**	28.01.22	Evaluate and review all clinical professionals undertaking private practice, and privilege rights, as well as appropriate indemnity insurance.	Discussions underway with regard to process requriements.		Clinical Director				30/09/2022			
PP8	**NOT STARTED**	28.01.22	Establish Clinical Advisory Committee	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				31/03/2023			
Commerical													
PP21	**IN PROGRESS**	28.01.22	Develop a private patient tariff for both self-pay and insured private patients	21/11/2022 - Refer to narrative in PP17. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		External provider				31/03/2023			
PP22	**IN PROGRESS**	28.01.22	Develop a new charge capture process and procedure and billing methodology and implement reflecting the new tariff structure.	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		External provider				31/03/2023			
PP25	**IN PROGRESS**	28.01.22	Develop a new process to produce cost estimates with prescribed methodology which ensures that the Trust complies with the Unfair Trading Practices Act.	Cost estimates provided for those that self pay. Work progressing for private patients and insurance companies. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		External provider				31/03/2023			
PP27	**IN PROGRESS**	28.01.22	Increase private income through exploiting opportunities to expand the clinical scope of the private patient service.	increased income by ensuring all activity is billed in line with process. Now charging for some element of care previously not charged for. Currently discussing expansion of radiology service. Any significant changes are closely linked to Strategy. **22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		Clinical Lead				31/03/2023			
Operational													
PP10	**OPEN**	28.01.22	Review patient pathway for private patients to ensure there is equity of service provision (MDT, CNS, psychology etc)	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				31/03/2023			
PP14	**IN PROGRESS**	28.01.22	Review management structure and reporting arrangements	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		COB / External Provider				31/03/2023			
PP15	**IN PROGRESS**	28.01.22	Review patient management arrangements by creating a Senior PP Manager role reporting to the COO	**22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		COB / External Provider				31/03/2023			
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.	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		WJ		PPMG agreed that current systems appropriate to capture information.		31/03/2023			

				patient activity for both inpatient and outpatients Report 2 - Private inpatient activity for a current day Report 3 - Radiology attendances, including exam type Report 3 - Radiology attendances, including exam type Patient KPI report (activity and phlebo) established (to be reviewed and signed off) Requirements provided to provide a single report that captures all activity at a patient level (which can be filter, including attendance month, year, department, activity type etc). This is dependent upon BI resources and prioritisation. BI resource currently focussed on implementation of DHCR. Dedicated finance resource required to produce monthly report for Senior Leadership Team. WPAS has now been deployed. There is ongoing work to ensure SOPs etc are aligned to ensure PPs are correctly recorded in the system to support ongoing activity reporting. 22/12/22 - Issues with the change in patient infomation systems are currently being worked through.									
PP43	**IN PROGRESS**	28.01.22	Undertake a commercial review of the HCaH contract and consider the creation establishment of a Trust peripatetic home chemotherapy service.	Given current constraints and pressures within SACT and wider services it is suggested this is consider during 2023/24 **.22/12/22 - Consultancy procured and providing on site support. Weekly progress reviews established with expertise guiding the strategic, commercial and operating actions via prioritised plan.**		PW	31/03/2023						

AUDIT COMMITTEE

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT ANNUAL REPORT 2021/2023

DATE OF MEETING	26/07/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Sara Walters, Clinical Audit Manager Catherine Pembroke, Clinical Lead for Audit and Quality Improvement Edwin Massey, Medical Director WBS Zoe Gibson, Interim Head of Trust Quality and Safety Jacinta Abraham, Executive Medical Director
PRESENTED BY	Zoe Gibson, Interim Head of Trust Quality and Safety
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	This Annual Report reflects the Trust Clinical Audit Programme delivered as defined by the Trust Clinical Audit plan and covers the period from 1st April 2021 to 31st March 2023. It provides an overview of the clinical audit activity and clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service.

	2 key achievements for the Trust Clinical Audit teams are firstly; the implementation of a digital system for clinical audit called AMaT : Audit management and tracking, which will streamline the audit process as well as dissemination of outcomes and tracking of actions. Secondly, the achievement of 'reasonable assurance rating' following an internal audit in January 2023 on the Trust Clinical Audit processes and governance, reported across all 5 objectives (Strategy, Plans, action plans, monitoring and learning). The report demonstrates the diverse portfolio of high-quality clinical audit undertaken across the Trust and describes how this is impacting on patient and donor care in our local services, as well as national and international platforms. The appendix provides detail on each project undertaken including the outcomes and recommendations made.

RECOMMENDATION / ACTIONS	**TO NOTE** the contents of the VUNHST Clinical Audit Annual Report 2021-2023 and to continue to support the function of Clinical Audit prior to the report being submitted to the Audit Committee.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCC QSMG	15/06/2023
VCC SLT	20/06/2023
EMB	26/06/2023
QS&P Committee	13/07/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS An overview of the Velindre section of the report was discussed at VCC QSMG and was approved prior to being sent to VCCSLT for information. The Trust report was presented at EMB and was well received. The main highlights included the Internal Audit Jan 2023: Reasonable Assurance Rating, the introduction of AMaT a digital audit tool and the development of the integrated quality	

and safety group. One of the key comments was to consider how AMaT and Tendable reporting can be integrated moving forward. The annual report was presented by Dr Catherine Pembroke and Dr Edwin Massey at the Quality, Safety and Performance Committee on the 13/07/2023 and **APPROVED** for onward submission to Audit Committee.

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

APPENDICES	
1	Clinical Audit Annual Report 2021-2023

1. SITUATION

This Annual Clinical Audit Report aims to provide an overview of the clinical audit activity and programme of work on clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service. There was no report submitted for the year 2021/22 as per strategic business continuity decisions taken during the Covid 19 pandemic. So, this Annual report aims to cover a 2-year period from April 2021 to the end of March 2023 which is reflected in the substantial content of the report.

2. BACKGROUND

The diversity of our Trust Clinical Audit portfolio reflects the wide-ranging clinical services provided and the clinical expertise that accompanies it. We have audits ranging from local, good practice interventions which have improved patient and donor experience, to significant contributions to National practice changing audits, some of which have received UK recognition and publication. We have met our criteria to participate in all required national audits and have also won awards through international conference poster submissions on our invaluable contribution of real-world patient data from VCC. Of note, in WBS a clinical audit cycle on preoperative anaemia testing has contributed to a successful Value Based Health Care award which is being used to scale up the initiative across Wales. Also, a significant change in eligibility criteria for blood donation was successfully implemented in Wales as demonstrated by the audit of For Assessment of

Individualised Risk (FAIR) below. We continue to provide an important leadership role, in our interactions with several organisations including the NHS Wales National Clinical Audit and Outcome Review Body, Wales Cancer Network, National Institute for Health and care Excellence,(NICE), Royal College of Radiology, and the Blood Health National Oversight Group.

3. ASSESSMENT

3.1 Velindre Cancer Centre Summary

The Audit team seek to support, facilitate all aspects of audit work within the cancer centre. Key performance indicators are defined through NICE and college guidelines, national audits, safety parameters and patient experience. Throughout the year 2021/2022 a total of 164 projects have been submitted, 98 active, 55 completed, 4 on hold and 7 discontinued. Throughout the year 2022/2023 a total of 159 projects have been submitted, 97 active, 48 completed, 2 on hold and 12 discontinued. Exemplary SSTs include Urology, Palliative Care, Neuro-oncology and Lung whose audits have contributed to peer reviewed, posters and awards. Areas of good practice remain patient-focused with addressing holistic needs for Urology patients, Macmillan Lung cancer pathways and Head and Neck patient surveys. The commitment to 30-day mortality review reinforces its importance and the high standards we uphold. The Lung SST All Wales Genetics Pathway Quality Improvement project has brought meaningful change to patients care on a national level. Treatment review of stereotactic radiosurgery for neuro-oncology has helped to inform practice and toxicity rates. Both of these projects will be presented at national conferences. The Advanced Future Planning Strategy, led by Palliative Care, was published in the British Medical Journal in February 2022.

3.2 Welsh Blood Service

The Welsh Blood Service (WBS) provides compatibility testing and other diagnostic services related to blood, cellular therapies and organs. The WBS also collects cells for cellular therapies and blood components, which are provided along with medicines derived from plasma, some drugs and vaccines to the NHS in Wales and also to other countries.

There are many synergies for the two operational divisions of the Trust. Bone marrow and stem cells are predominantly supplied by the WBS for the treatment and cure of cancers. 25-30% of blood components are provided as part of the supportive treatment for patients with cancer. More blood components are transfused in the Velindre Cancer Centre than some general hospitals in Wales. The stem cells for treating cancers and other disorders are collected in the Velindre Cancer Centre site.

Despite the challenges of the pandemic, with changes in the way we provide existing services, and the addition of new services such as the national distribution of COVID vaccines, clinical audit has continued to be performed to assure the governance of the organisation. The WBS contributes to international audit and performance monitoring through UK 4 nation, European and wider international initiatives in all areas. These include the Serious Hazards of Transfusion haemovigilance scheme for patients and donors, The UK Health Security Agency (UKHSA) Infectious Diseases Annual Surveillance Report and European Blood Alliance bench marking surveys.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Velindre Cancer Centre

The audit report does highlight the need for improvement within the service and we will aim to implement these in the coming years. In line with Velindre Future Program, we aim to align ourselves with Service Improvement, Patient Safety, Morbidity and Mortality and Education to create a Quality Improvement Hub. The intention for this is to provide a focus group to help educate, support and mentor project proposals to ensure maximal output and to implement sustained change. In order to encourage a culture of Quality Improvement (QI) and Audit within the Cancer Centre we aim to engage with SSTs by improving the dialogue between our two groups to ensure we address key areas of concern. We will require SSTs to define the local implications from the National Audits we participate in at the end of every audit year. We also need to foster education and support for our trainees and trainers so that they are well versed in the audit/ QI methodologies and principles. We also realise there is a need to present this ongoing work for the benefit of others and proposals are underway for a six-monthly hospital-wide audit meeting.

4.2 Welsh Blood Service

Audit of the appropriate use of these services internally for our own patients and across Wales are an important part of assurance for the Trust. Unlike VCC the WBS does not have staff specifically employed to support or undertake audit other than the generic requirement in the job descriptions and job plans of staff in clinical roles to participate in audit.

Key points that need addressing

- Enablement of a consistent trust wide culture of innovation, learning, improvement and clinical audit to support the provision of safe, effective, person-centred care provision.
- Provision of Clinical Audit support across both divisions.

- The potential for improved integration of audit, quality and service improvement in quality improvement hubs
- Limited opportunities to disseminate and showcase work within the Trust, especially in the absence of an integrated audit team
- The need to adapt a whole system approach that enables collaborative working both with all Health Boards and Trusts across Wales, and internally within our own departments.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Choose a domain/domains.
	Safe ☐ Timely ☐ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☐

	Clinical Audit is closely aligned to the Trust Quality and Safety Agenda as it embeds quality and learning and drives a culture of continuous improvement.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Click or tap here to enter text.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	N/A
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust

CLINICAL AUDIT Report 2021/2023

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT REPORT 2021/2023

1. INTRODUCTION

This Annual Clinical Audit Report aims to provide an overview of the clinical audit activity and programme of work on clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service. There was no report submitted for the year 2021/22 as per strategic business continuity decisions taken during the Covid 19 pandemic. So this Annual report aims to cover a 2 year period from April 2021 to the end of March 2023 which is reflected in the substantial content of the report.

2. EXECUTIVE SUMMARY

In keeping with our organisational focus on Quality and Safe care, Clinical Audit continues to evolve within the Trust and has played an increasingly important role in helping us to evidence and embed Quality within our systems. With strong clinical leadership, organisational support and new dedicated roles in place, there is a growing confidence and ambition for clinical audit at VUNHST. This is reflected in the Internal Audit feedback demonstrating reasonable assurance and the successful introduction of a digital Audit tool AMaT (described below) which can be used across the Trust. The impact of this digital tool will be transformational and allow us to maximise the measurement and learning from clinical audit outcomes.

Clinical Audit is a key member of the relatively newly formed Trust Integrated Quality and Safety Group and is part of the Quality and Safety Management groups within the divisions, reporting to the Trust Quality Safety and Performance committee. The importance of triangulation of clinical outcomes with learning and improvement, and good business intelligence to support the clinical audit function, have been identified as 2 important themes, through these committees. There is a renewed interest in Clinical Quality Improvement (QI) and the need to identify champions, train our staff and embed a culture of QI across the Trust as a driver for clinical transformation. This is aligned to the Safe Care Collaborative agenda which the Trust has fully signed up to.

The diversity of our Trust Clinical Audit portfolio reflects the wide-ranging clinical services provided and the clinical expertise that accompanies it. We have audits ranging from local, good practice interventions which have improved patient and donor experience, to significant contributions to National practice changing audits, some of which have received UK recognition and publication. We have met our criteria to participate in all required national audits and have also won awards through international conference poster submissions on our invaluable contribution of real-world patient data from VCC. Of note, in WBS a clinical audit cycle on pre operative anaemia testing has contributed to a successful Value Based Health Care award which is being used to scale up the initiative across Wales. Also, a significant change in eligibility criteria for blood donation was successfully implemented in Wales as demonstrated by the audit of For Assessment of Individualised Risk (FAIR) below. We continue to provide an important leadership role, in our interactions with several organisations including the NHS Wales National Clinical Audit and Outcome Review Body, Wales Cancer Network, National Institute for Health and care Excellence, (NICE), Royal College of Radiology, and the Blood Health National Oversight Group

We recently submitted our Trust Clinical Audit plan for the coming year 2023/24 and we have described within it, a clear set of priorities that we intend to achieve moving forward. We can build on our current position of a strong commitment and understanding of the value of clinical audit in blood and cancer as evidenced in this comprehensive report.

3.0 VELINDRE UNIVERSITY NHS TRUST

3.1 Internal Audit of Trust Clinical Audit Process and Governance

A recent internal audit (January 2023) sought to provide the Trust with assurance that Velindre University NHS Trust has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services. Overall, a 'Reasonable' assurance rating was reported across all 5 objectives (Strategy, Plans, action plans, monitoring and learning)
The following areas of improvement were identified and relevant actions are now being taken which will be fully realised in this 2023/34 Clinical Audit plan.:

- Particular focus will now be given to ensure that the Clinical Audit Actions are SMART and regularly reviewed
- Discussions are underway to with regards to the feasibility of a centralised clinical audit team or exploring how WBS and VCC can work together ensuring processes are aligned across the organisation
- Annual audit engagement with each SST with robust documented discussion including annual plan, progress, learning and actions.
- Review of SST meetings to establish how discussions are documented with progress of clinical audits.
- The full implementation of a Digital Clinical Audit platform AMaT will be achieved by March 2024 Across Trust, which will provide the foundation for standardisation of approach and systematic reporting.

3.2 Trust Integrated Quality and Safety Group

The establishment of this Trust group has helped to centrally position Clinical Audit to ensure that all Clinical Audit Activity is captured and that it is informed and influenced by the triangulation of all available sources of Quality data. The Business Intelligence system to support this triangulation is in its early stages but aims to eventually have a live dashboard that can be interrogated.
High level incidents and themes from complaints that have been identified by the group for inclusion in the planned programme include communication, the treatment helpline, SACT bookings and the offer of a chaperone. Work on developing projects around some of these issues are underway and will be added to the plan in due course.
In addition, the group provides a feedback mechanism so that learning can be shared and issues identified can be escalated.

3.3 AMaT

AMaT is a web-based Audit Management and Tracking tool to streamline all of auditing requirements into one simple, easy-to-use system. Innovation purchased the AMaT license and software on behalf of the organisation in April 2022 for a 2 year period; this was funded by HTW and was supported by the executive team in March 2022. The funding will cover the cost of the system until 31st March 2024, at this stage financial resource will be required to renew the licence.

A number of LHB's have purchased AMaT recently and are in the process of implementation. There could be a scope to make it an all Wales system.

It will help modernise the clinical audit department and help shape the work we are undertaking with regards to defining the project approval process. It will digitise the manual system we currently use and remove the administrative task of reporting and following up of actions.

Users can input and access data in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility.

AMaT is a web-based system, you can therefore securely share information with others instantly and can be customised to meet the specific needs of departments.

There are a number of Modules available:

- Clinical Audit and improvement projects
- Ward, Area & Service projects
- Cumulative long-term audits and improvement projects
- Guidance activity and compliance statements
- Inspections recommendations & Actions
- Quality Improvement
- Mortality and Morbidity Review (MaMR) (restrictions)

4.0 VELINDRE CANCER CENTRE ANNUAL REPORT

Canolfan Ganser Felindre
Velindre Cancer Centre

4.1 Foreword: Velindre Cancer Centre

This report demonstrates that the clinical audit department at Velindre Cancer Centre, led by Sara Walters, has a successful framework in which to support professional groups in completing projects. Our exemplary involvement with six National Audits not only raises the profile of the hospital but ensures we're contributing and holding ourselves account to the national benchmarking of standards. The department has also been actively involved in Site-Specific Team meetings to ensure their priorities and interests are supported. Introduction of an Audit Management and Tracking system (AMaT) will allow for streamlining of processes and dissemination of work within the hospital.

The cancer centre as whole, as well as the audit department, has been subject to unprecedented challenges in terms of both workload and limitations in resources. This is reflected in the smaller number of projects undertaken this year. The Service Improvement Group has had to pause its activity due to COVID secondments and the team and subsequent education/ mentorship have ceased temporarily. We are now working closer together so that respective teams have opportunities for greater support and closer collaboration in the future. Patient safety and high quality care has to be a priority and our aim is to encourage and create space for Audit and Quality Improvement (QI) within the clinical environment, so that this can become embedded within our culture at VCC. We aspire to create an environment for continuous learning and mentorship so we can deliver the high quality healthcare we strive to achieve.

Key points that need addressing

- Fostering a culture of Audit/QI/Patient Safety reporting within Velindre Cancer Centre
- Integration of Audit and Service Improvement teams to create a Quality Improvement Hub
- Improve Senior House Officer engagement with audit and QI
- Increase patient engagement/representation in majority of projects
- Increase opportunities to disseminate and showcase work within hospital
- Improve the relevance of National Audit data to our local population. This needs to be better understood and articulated.

In order to address these key issues, we now have a 3-year plan in which we outline some suggestions in improving systems so that QI and Audit become core values amongst all professional groups. These include:

Education

In an attempt to foster a culture of audit and QI within the cancer centre we need to ensure people are well equipped with the core principles and skillsets. A 'Fundamentals of Quality Improvement' led by HEIW will be held for trainees on 27th September.

We also aim to deliver a VCC-specific specialty-trainee/trainer 9-month educational QI/Audit program with structured academic workshops and project-specific mentorship. (Please see attached publication and proposed framework). We will ensure that patient engagement and participation are a vital component of the program. This will be a pilot project and will aim to commence in September 2023. An annual QI/Audit event will be held in June following the academic program. The objective would be for trainees to showcase their work to the hospital and for others to learn. There would be prize giving to demonstrate recognition of outstanding achievements. If, following formal review, this is thought to be successful we would aim to expand this to other professional groups including nursing, pharmacists, radiotherapy and physics in subsequent years.

We also need to revise the induction packs for SHOs who typically rotate to VCC 3-6 monthly. This would include

- A brief survey to ascertain prior knowledge and experience
- A written summary of audit/QI principles including references for further reading
- An academic fundamentals session held by service improvement/audit team
- A list of 'ready to go' projects defined as relevant by previous SHO cohort/SSTs. Designed to be short, achievable projects with 3-6 month placements

Departmental Engagement

We propose bi-annual meetings with Site-Specific Teams and professional groups (physics, pharmacy, nursing and radiotherapy) in order to address the following key issues

- Annual key-performance indicators for that year (start with 1-2 a year)
- Patient reported Outcome Measures (PROMS)
- Patient safety (by encouraging a culture of DATIX reporting within SST and teams)
- This will allow important clinical and safety issues to be addressed as well as ensuring that projects are properly planned, completed, supervised and reviewed
- How National Audits are applicable to VCC patient population

We also hope to connect with the Patient Safety group who are aiming to foster a culture of openness and constructive discussion concerning DATIX reporting. This will serve as platforms for further QI/audit projects.

Dissemination of Information

In order to display the successful audit work taking place within the cancer centre we propose a six-monthly hospital-wide Audit/QI afternoon. All professional groups will be invited to present completed projects either in oral or poster formats. A quarterly newsletter highlighting success stories would supplement this.

Electronic Audit System

As an institution, we need to move away from excel spreadsheets. Introduction of AMaT will allow for streamlining of processes and dissemination of information. We hope to be able to fully utilise this resource and encourage SSTs to collate KPIs and PROMS

Clinical Oncology Quality Improvement and Audit Forum

We will be attending the Clinical Oncology Quality Improvement and Audit Forum held at the Royal College of Radiologists. We hope this will allow us to network, learn and implement best practice within the organisation

In Conclusion

This report demonstrates the substantial audit activity and the hard work of others taking place within Velindre Cancer Centre. This is particularly impressive given the unprecedented challenges the currently faced by the NHS. It does, however, demonstrate a need to align audit and service improvement departments in an attempt to develop a QI hub. It highlights a need to build upon education and mentorship as well as departmental engagement to ensure the projects are most applicable to the population we serve. Looking to the future, through the newly formed Velindre Futures Programme at VCC and the local implementation of the National Quality and Safety Framework, I have every confidence that there are significant opportunities for Clinical Audit and QI to be embedded within our organisation in a meaningful way. I would like to acknowledge Ms Sara Walters and the audit department who have worked exceptionally during a difficult time.

Catherine Pembroke
Clinical Lead for Audit and Quality Improvement

4.2 Velindre Cancer Centre Summary

The Clinical Audit Department remains an essential pillar within the Clinical Governance structure in Velindre Cancer Centre. The Audit department ensures the Cancer Centre can demonstrate, sustain and improve high quality of care throughout all its departments.
The Clinical Audit team continue to provide and quality assure data for the National Clinical Audit and Outcome Review Plan. Participating in these collaborative projects ensures that we are involved in the dialogue and improving the quality of care on a national scale. Predetermined performance indicators allow us to benchmark our own practice ensuring we can demonstrate good standards of care within our SSTs. Greater involvement with Site Specific Team (SST) and undergraduate medical students has been a huge success and will continue to strengthen in the years to come.

The Audit team seek to support, facilitate all aspects of audit work within the cancer centre. Key performance indicators are defined through NICE and college guidelines, national audits, safety parameters and patient experience. Throughout the year 2021/2022 a total of 164 projects have been submitted, 98 active, 55 completed, 4 on hold and 7 discontinued. Throughout the year 2022/2023 a total of 159 projects have been submitted, 97 active, 48 completed, 2 on hold and 12 discontinued. Exemplary SSTs include Urology, Palliative Care, Neuro-oncology and Lung whose audits have contributed to peer reviewed, posters and awards. Areas of good practice remain patient-focused with addressing holistic needs for Urology patients, Macmillan Lung cancer pathways and Head and Neck patient surveys. The commitment to 30 day mortality review reinforces its importance and the high standards we uphold. The Lung SST All Wales Genetics Pathway Quality Improvement project has brought meaningful change to patients care on a national level. Treatment review of stereotactic radiosurgery for neuro-oncology has helped to inform practice and toxicity rates. Both of these projects will be presented at national conferences. The Advanced Future Planning Strategy, led by Palliative Care, was published in the British Medical Journal in February 2022.

The audit report does highlight the need for improvement within the service and we will aim to implement these in the coming years. In line with Velindre Future Program, we aim to align ourselves with Service Improvement, Patient Safety, Morbidity and Mortality and Education to create a Quality Improvement Hub. The intention for this is to provide a focus group to help educate, support and mentor project proposals to ensure maximal output and to implement sustained change. In order to encourage a culture of Quality Improvement (QI) and Audit within the Cancer Centre we aim to engage with SSTs by improving the dialogue between our two groups to ensure we address key areas of concern. We will require SSTs to define the local implications from the National Audits we participate in at the end of every audit year. We also need to foster education and support for our trainees and trainers so that they are well versed in the audit/ QI methodologies and principles. We also realise there is a need to present this ongoing work for the benefit of others and proposals are underway for a six monthly hospital-wide audit meeting.

The annual report demonstrates the consistent commitment from healthcare professionals working within Velindre Cancer Centre to fully engage with clinical audit as a driver for change and improve the quality of care for our patients.

4.2.1 Infographic

4.3 CLINICAL AUDIT DEPARTMENT

Clinical Lead for Audit and Improvement	Catherine Pembroke
Clinical Audit Manager	Sara Walters
Clinical Audit Officer	Rachael Kipling
Clinical Audit Support Officer	Becky Quinlan
Clinical Audit Support Officer	Janzib Alyas

4.4 National Audit

Velindre participates in the cancer related national audits set out by the National Clinical Audit and Patients Outcomes Programme (NCAPOP), where annual participation is a requirement. These include NLCA (Lung), NOGCA (Oesophago-gastric), and Prostate Cancer (NPCA), Breast (NABCOP), NBoCA (Bowel), NACEL (Care at end of life).

The Welsh Cancer Network supports NHS Wales' participation in National Cancer Audit and have published A Cancer Improvement Plan for NHS Wales 2023-2026 which sets out the ambition for Wales to improve cancer patient outcomes and reduce health inequalities.

A new national centre of excellence to strengthen NHS cancer services by looking at treatments and patient outcomes right across the country has been established. The National Cancer Audit Collaborating Centre will deliver five new national cancer audits in breast cancer (primary and metastatic), ovarian, pancreatic, non-Hodgkin lymphoma and kidney cancer. These will be added to the planned programme once established.

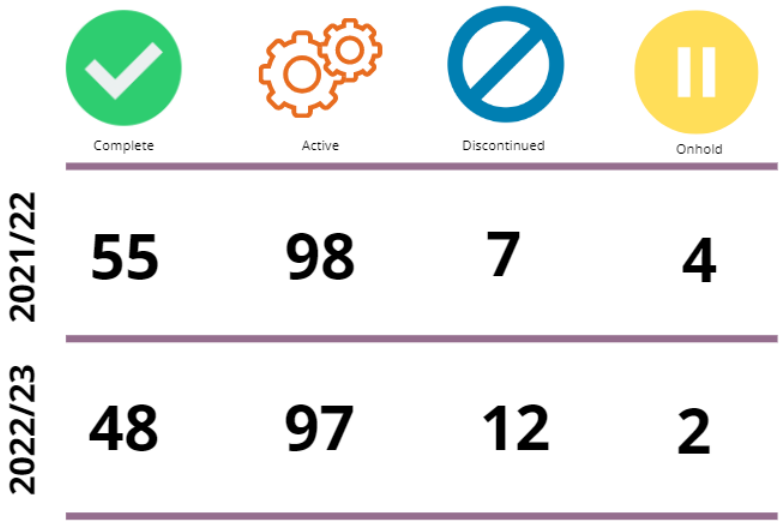
Other National topic specific audits are set by NCEPOD (National Confidential Enquiry for Patient Outcome and Death), RCR (Royal College of Radiologists audits) and NOTCH (The National Oncology Trainees Collaborative for Healthcare Research.

The team will work closely with the SST's to ensure key recommendations and areas for learning from National audits are identified and implemented where appropriate. As these National audits are led by the WCN and data submitted from a health board level the recommendations are not always applicable to Velindre services.

4.5 Clinical Audit Activity

The table below demonstrates the current audit activity within Velindre Cancer Centre.

	Total 2021/2022	**Total 2022/2023**
Completed	55	48
Active	53	45
Ongoing/Continuous	45	52
On Hold	4	2
Discontinued	7	12
Total	**164**	**159**



4.5.1 Discontinued audits

Discontinued Audit	Reason
CDK4-6 inhibitors during the COVID- 19 pandemic – administration, safety & outcomes. Real world data from the UK.	This project will be discontinued. National data has been published and therefore too late for data submission.
An evaluation of patient understanding and experience of bowel preparation in patients undergoing radical radiotherapy for gynaecological cancer.	This project was part of a masters and was originally put on hold due to COVID. The lead has now left Velindre and the project has been discontinued.
Review of Enteral feeding in Head & Neck patients undergoing radical radiotherapy during COVID 19	With the rest of the Patient Support Unit team, It was a large project and ultimately we didn't have the capacity or staffing to devote the time that was required to complete it.
Use of single agent check-point inhibitor pembrolizumab in metastatic non-small cell lung cancer	Was delayed due to COVID and maternity leave. this will be discontinued as data collected previously is now outdated
Review of treating Cancer Associated Thrombosis (CAT) in patients with primary brain tumours	Discontinued no SSC attended to undertake and no other resource to take forward
Service Evaluation - Real World Experience of Foundation Medicine Testing at Velindre Cancer Centre	Discontinued. CD contacted on numerous occasions email now undeliverable. Unable to get copy of results.
A service evaluation of physiotherapy unscheduled care referrals	Audit was on hold due to the changes going on within unscheduled care/ ambulatory care at the moment. It is now felt that it was no longer relevant, will send any updates.
Audit of neutropenic septic admissions and dose delay/dose reductions with FEC100-T adjuvant and neoadjuvant chemotherapy given with pegfilgrastim	Project lead left the organisation and there is no resource to complete the project.
Breast cancer radiotherapy and secondary cancer	No SSC uptake and no resource within the team
National Service Evaluation project, evaluating the "Safety and Efficacy of Atezolizumab in combination with *nab*-Paclitaxel	Missed national deadline for submission this was due to the clinical governance concerns raised by VCC with the RMH
PARP inhibitors	Unable to start this audit due to other commitments, thus discontinued.

Nasogastric (NG) tubes patient experience	Dietitians & Speech therapists that were doing this audit did not have time or resources to complete it.
Outcome of ADT and docetaxel for hormone-sensitive metastatic prostate cancer	No longer required due to change in practice
A review of dry mouth and its management	Audit has been discontinued as too busy with pandemic and related clinical pressures.
DM, BMI, Chemo Regime , PS and comorbidities Influencing Clinical Outcome in patients with Metastatic Pancreatic Cancers	Audit discontinued as lead rotated to Swansea.
Investigation & Management of iron deficiency anaemia in patients with gastrointestinal malignancy:	Paused implementation of iron infusion policy due to COVID restrictions and pressures on day unit etc. data was never finished, would now be too old and not relevant so close audit down.
Scoping project Patient views on how the service should look	Moved to patient experience
Audit on Measure yourself concerns and wellbeing questionnaire	Staff Members undertaking audit have left the trust, Other staff unaware of Audit.

4.6 Clinical Audit Action Plan

A clinical audit action plan has been developed and is monitored by the department in conjunction with the SST's. All audit activity and action plans are discussed within the quarterly meetings and updated accordingly. The introduction of AMaT will help automate this and leads will be required to update their actions in a timely manner. A SMART action guide will be developed to assist leads to develop SMART action plans.

4.7 Planned Clinical Audit Programme

The Planned Clinical Audit Programme is a proactive approach to carrying out audit within each SST. The programme is developed before the start of each financial year with the aim of identifying areas for audit including National and local priorities. The programme is prominently made up of key indicators of practice, NICE guidelines, patient experience, local concern and national audits; these are identified and prioritised within each SST through the implementation of new radiotherapy techniques, the introduction of new drugs with specific toxicities and any serious adverse events. The Trust Integrated Quality Group will help develop and inform the plan moving forward.

4.8 Student Selected Components (SSCs) at Velindre Cancer Centre

Cardiff School of Medicine offers a range of opportunities to tailor learning and study specific aspects in depth. As well as intercalating and opportunities to study abroad, there are hundreds of Student Selected Components (SSCs) from which to choose.
For those students with a real interest in oncology this offers an opportunity to work closely with an oncology consultant. There is also the opportunity to work collaboratively with oncologists and clinicians in other hospitals, e.g. surgeons, gastroenterologists, radiologists. Past students have had their work published in scientific journals and have presented their work in International Meetings.
The Clinical Audit Department inducts and supervises the 3rd, 4th and 5th year medical students (SSC) each year. During 2021/22 10 year 3 and 10 year 4 students attended to undertake the or SSC at Velindre. In addition, one year 2 and one year 5 electives also attended. For Year 2022/23 6 year 3 and 8 year 4 attended.

We provide the medical students with the opportunity to attend a number of interesting short virtual sessions on key oncological topics including immunotherapy, radiotherapy and clinical trials. These sessions are provided by the junior doctors and have received excellent feedback from the students.

A new development for the academic year 2022/23, included a virtual presentation event during the last week of their 6-week block. This will provide an opportunity to present their work at a multidisciplinary forum and will be provided with a certificate for presenting. The presentations are judged by an expert panel and the top 3 presenters received a prize. The aim of this session is to provide an opportunity for all students to present their work, which will be a key skill expected of clinicians throughout their career.

4.9 Site /Service Specific Teams (SST)

The SST's key roles are to provide a forum for multi-disciplinary service planning, development, audit and research in tumour site and service specific issues, providing recommendations to Velindre Cancer Centre on required service changes and approaches to realising these. They are also required to be accountable for the delivery of excellent, efficient, equitable and safe tumour specific service by VCC and to monitor quality and timeliness of services according to national standards.

4.10 Breast Site Specific Team
4.11 Colorectal Site Specific Team
4.12 Gynaecology Site Specific Team
4.13 Head & Neck Site Specific Team
4.14 Lung Site Specific Team
4.15 Palliative Care Service Specific Team
4.16 UGI Site Specific Team
4.17 Urology Site Specific Team
4.18 Neuro-oncology Site Specific Team
4.19 Other Sites and Services

4.10 BREAST SITE SPECIFIC TEAM

4.10.1 Breast Clinical Audit Activity

	Complete	Active	Discontinued	Onhold
2021/22	6	5	1	0
2022/23	6	2	3	0

**Figures exclude mandatory national audits and continuous monitoring*

4.10.2 National Audits and Continuous Monitoring

4.10.2.1 The National Audit of Breast Cancer in Older Patients (NABCOP) was established in April 2016. It assesses the processes of care and outcomes for women aged over 70 years compared with women 50-69 years. NABCOP's results will help NHS breast cancer services in England and Wales to benchmark and improve the care delivered to these women. It is run by the Association of Breast Surgery and the Clinical Effectiveness Unit at the Royal College of Surgeons of England and is commissioned by HQIP.

The NATCAN's programme of work includes two new breast cancer audits. The first audit will look at primary breast cancer, while the second will focus on secondary (metastatic) breast cancer, for women and men of all ages.

The CEU has been managing the NABCOP since April 2016, and the work of the NABCOP and lessons learned will be used to inform the planning and delivery of the two new audits. Resources from the NABCOP such as the guide to the breast cancer pathway for older women, and the fitness assessment for older patients in the breast clinic, continue to be made available.

4.10.4 Areas of good practice and improvement

4.10.4.1 Re-audit ER/HER2 misreporting

An audit was undertaken during 2017 following an incident where by a patient was treated as having oestrogen receptor negative breast cancer (ER) on the basis of a negative ER result instead of positive (+). A review of the medical records indicated an error in the noting of the ER status. Therefore, the patient was treated on this basis rather than the correct ER positive result. The audit identified areas for improvement and an action plan was devised. A re-audit was scheduled during 2020 however there have been delays in reporting due to COVID.
In total the records of 1145 were reviewed, and no error in treatment were identified. There were a small number of documentation errors, however this did not impact on treatment. There has been a significant improvement in the availability of source data within WCP, principally the histopathology results for patients diagnosed through the screening service at Breast Test Wales. Limitations of the CMDS function in Canisc/WCP means that ER/HER2 are not recorded as a set field making interrogation of data difficult.

4.10.4.2 Evaluation of the BAPS App

The BAPS app was launched in February 2019, with the aim of standardising information given to patients post breast surgery in a more interactive fashion, empowering patients with an understanding of why the exercises are important, motivating them to achieve their goals in their own home and optimising the patient care pathway from surgery to radiotherapy.

In order to assess patient feedback at the point of planning for radiotherapy to assess the usage and effectiveness of the app, a patient survey was devised in October 2021 - 50 Questionnaires were distributed to patients who were undergoing RT with a 54% response rate. Only 41% of responses were aware of the baps app. 64% of these were told about it by their breast care nurse. 30% of these patients actually used the baps app post surgery. Recommendations include:

- Need greater advertising of the baps app to widen use.
- Need to revise the inspirational hold element of the app

4.10.4.3. The impact of the COVID pandemic on our breast cancer patients

The main aim of the project was to determine whether the COVID-19 pandemic had an impact on the stage of breast cancer at referral. The results demonstrated a higher proportion of advanced breast cancers were seen amongst the post-COVID cohort. Stage I was the most common stage in the pre-COVID group, whereas Stage IIA was most commonly seen in those referred post-COVID. T stage and N stage of early cancers were similar in both groups. Treatment patterns also differed with more patients being referred for neoadjuvant chemotherapy post COVID.

4.10.5 Posters and Publications

4.10.5.1 Eribulin Treatment for Patients with Metastatic Breast Cancer: The UK Experience - A Multicentre Retrospective Study

This study examined real-world data from patients who received eribulin for metastatic breast cancer (MBC) collected from 14 hospitals across the UK.
Anonymized data were collected retrospectively from patients with MBC who had received eribulin. The data included the hormone-receptor status, histological diagnosis, age, prior chemotherapy, response to eribulin, progression-free survival (PFS), and overall survival (OS). Among 577 patients analysed, the median age was 56 years, and most patients (73%) were estrogen-receptor positive. The median OS was 288 days and the PFS was 117 days. The median OS was higher among older patients. The median OS was also higher in patients who received eribulin after fewer prior lines of chemotherapy

These retrospective data suggest that eribulin can be successfully used in older patients with MBC. Eribulin treatment was more effective in earlier-line settings, which, while predictable, supports consideration of eribulin as a second-line treatment option.

4.11 COLORECTAL SITE SPECIFIC TEAM

4.11.1 Colorectal Clinical Audit Activity

	Complete	Active	Discontinued	Onhold
2021/22	1	9	0	0
2022/23	1	9	1	0

**Figures exclude mandatory national audits and continuous monitoring*

4.11.2 National Audits and Continuous Monitoring

4.11.2.1 The National Bowel Cancer Audit is a collaborative, national clinical audit for bowel cancer, including colon and rectal cancer. It aims to improve the quality of care and survival of patients with bowel cancer; it is now well established and has collected data since 2005. The National Bowel Cancer Audit is designed to provide vital information with regards to diagnosis, treatment, and outcomes; the main focus is to help make sure that people with bowel cancer receive the best care possible. However Systemic Anti-Cancer Therapy (SACT) and Radiotherapy data is not available for patients treated in Wales. NBOCA are currently in the process of obtaining access to RTDS data for Wales regarding.

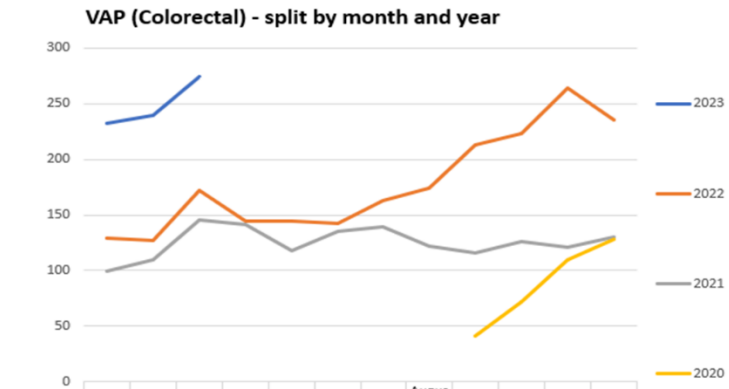
4.11.3 Areas of good practice and improvement

8.2.3.1 Colorectal 'Support Group' - There is currently no Support Group in the South East Wales area for people with or those affected by Colorectal/Bowel Cancer. For some time Velindre have been looking at setting up a support group and wanted to find out if this is something that people would find helpful. The survey also provided the opportunity to identify if there are any specific topics/issues that people are keen to discuss and topics that might be useful. The survey confirmed that there was a lot of interest in a colorectal support group in the area. However, there were patients who felt that it wasn't for them. The colorectal team are working on setting this up, potentially in a virtual format in the first instance.

4.11.3.2 VAP Clinic

In the past 2.5 years the VAP clinic has undertaken 4500 CRC assessments. The team now assess approximately 250 CRC patient per month and CRC makes up 61% of the VAP workload.

As you can see from the graph below – CRC VAP has grown year on year.



	Jan	Feb	Mar	Apr	May	June	July	August	Sept	Oct	Nov	Dec
2023	232	240	274									
2022	129	127	172	144	144	142	163	174	213	223	264	235
2021	99	110	145	141	118	135	139	122	116	126	121	130
2020									41	72	110	128

The are two main CRC prescribers who aim to be autonomous and not 'bother' the CRC teams unless outside out scope of experience. This enables the consultants to concentrate on the new referrals, more complex patients or those needing scan results.

4.11.3.3 Neoadjuvant Radiotherapy

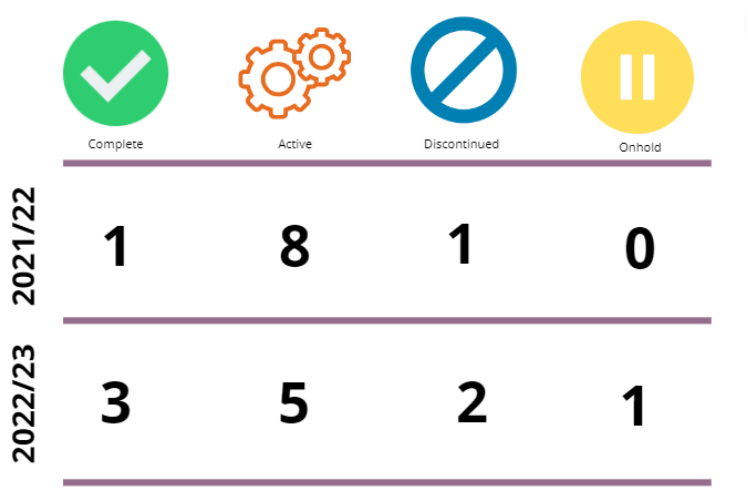
The Colorectal team have adopted the use of Total Neoadjuvant Therapy into our practice in keeping with the most relevant and up to date clinical trials data. This is on the audit plan for 2023/24

4.11.3.4 DPYD Testing

We reached 1000 patients tested in Wales for DPYD testing, an initiative led by the colorectal SST with more than 70 patients testing with a DPYD variant and having their does adjusted to prevent severe toxicity

4.12 GYNAECOLOGY SITE SPECIFIC TEAM

4.12.1 Gynaecology Clinical Audit Activity



**Figures exclude mandatory national audits and continuous monitoring*

4.12.2 National Audits and Continuous Monitoring

There are currently no mandatory national audits within this site

4.12.3 Areas of good practice and improvement

4.12.3.1 Image guided brachytherapy has been introduced into Velindre Cancer Centre in the last few years. It is important to monitor outcomes following its introduction

Historically patients all received the same dose in the same area. Since 2016, IGBT (image guided brachytherapy) has been used at Velindre, where MRI (or CT) may be used to create a more specific treatment plan for the patient and their cancer. 193 Patients' data with cervical cancer were collected in this retrospective study. They were divided into 2 cohorts, patients who had treatment before March 2016 had standard planning brachytherapy (control) and patients who had treatment after March 2016, who received IGBT

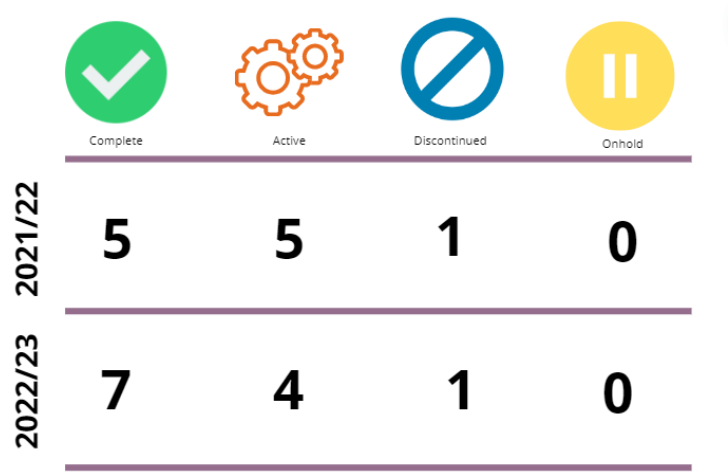
Comparison of the cohort groups found 35.3% of the control group had died in contrast to 30.1% of the protocol group. Between both groups, 113 patients were found to have at least 1 toxicity on the LENTSOMA grading system. 82.4% of the control group developed a toxicity associated with their radiotherapy/brachytherapy whereas the protocol group only had 56.3% of patients with a reported toxicity.

Overall, from all of the data, we can see that the IGBT cohort had much better local control and a reduced proportion of the cohort developing toxicity from the Brachytherapy compared to the standard planning cohort.

Recommendations: Continue following up patients and re-do yearly/ 2 yearly. Additionally, data from previous years (2014 and before) could be used to increase the data from the standard planning (control) cohort.

4.13 HEAD & NECK SITE SPECIFIC TEAM

4.13.1 Head & Neck Clinical Audit Activity



	Complete	Active	Discontinued	Onhold
2021/22	5	5	1	0
2022/23	7	4	1	0

**Figures exclude mandatory national audits and continuous monitoring*

4.13.2 National Audits and Continuous Monitoring

There are currently no mandatory national audits within this site.

4.13.3 Areas of good practice and improvement

4.13.3.1 To assess the use of Pembrolizumab in the metastatic /non resectable HNSCC at Velindre Cancer Centre

The introduction of single agent Pembrolizumab took place during the background of the Covid-19 pandemic. Initially, immunotherapy was utilised as a short-term goal to avoid myelosuppression, but as experience with the drug grows, it is increasingly seen and utilised as an option for patients whom are relatively asymptomatic or have non-bulky disease.

CPS scoring appears to be under-utilised, with only 38% of eligible patients having a CPS performed. One patient had a PDL-1 score performed. As at the time of writing, this audit did not reveal a trend, potentially due to the small sample size.

The most common reason for stopping Pembrolizumab therapy was patient deterioration or end of life (50%). The second most common reason was disease progression (both clinical and radiological) (25%). The number of patients in this audit were small, however this result illustrates the poor prognosis of patients with metastatic or locally advanced SCC of the head and neck that do not promptly respond to systemic therapies. Of the 38% of patients that had CPS performed, two patients had CPS scores (20 and 85) that could suggest a positive response to Pembrolizumab, however, alternative treatments were chosen. Further inspection of these patient's notes showed that the patient with a CPS score of 85 had disease recurrence invading the vertebra and brachial plexus. The second patient with CPS 20 was found to have progressive lung and new liver metastases. In both cases, chemotherapy was chosen as 1st line treatment - presumably due to the site of recurrence, associated morbidity and desire for prompt disease response. Physician preference would additionally be a contributing factor.

Recommendations: Results to be fed back to the Head and Neck department and explore the teams experience with the drug to date including reasons for low CPS scoring requests. As a department we can aim to device a system to ensure appropriate testing and utilisation is implemented. The aim would be to re-audit approximately 1 year after implementation.

4.13.3.2 Total treatment time and time from surgery to RT in Post-Operative Radiotherapy in Head and Neck Cancer

Results of our Service, Treatment within 6 weeks, Target: 96%, VCC Compliance 54%. Treatment within 5 weeks, Target 75%, VCC Compliance 20%. Lack of staff in Pathology department has been recognised, this audit data can be used to create a business case to hire more Pathologist.

Discussion among Oncology consultants if, a rota can be made to expedite start of RT. 46 Patients in 1 years = 4 patients in 1 month, i.e. 1 patient / week on Average. Review and Compare LRC and mortality between above three groups and see if it has made a difference.

4.14 LUNG SITE SPECIFIC TEAM

4.14.1 Lung Clinical Audit Activity

	Complete	Active	Discontinued	Onhold
2021/22	6	5	1	0
2022/23	2	4	0	0

**Figures exclude mandatory national audits and continuous monitoring*

4.14.2 National Audits and Continuous Monitoring

4.14.2.1 The National Lung Cancer Audit (NLCA) was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries and varied considerably between organisations within the UK. The audit began collecting data nationally in 2005, and since then has become an exemplar of national cancer audit.

The NLCA has previously achieved outstanding levels of NHS participation with data being used to drive improvements in the quality of care for people with lung cancer. The RCP aims to build on this success by delivering a new NLCA that incorporates key advances in the field of lung cancer, diagnosis and treatment, whilst retaining the most successful elements of the previous audit.

Wales has managed to reach the target of 90% of lung cancer patients being assessed by a lung cancer nurse specialist, a significant benefit to our patients and a testament to the dedication of our nurses and the investment from the health boards.

NSCLC resection rate (15.8%), chemotherapy in SCLC (65%) and systemic anticancer therapy for stage IIIB–IV, PS 0–1 NSCLC patients (54%) remain below the audit standards and have remained static for the past few years. There was no formal outlier process this year, but on these measures, Wales does not appear to be performing as well as England.

There will be multiple reasons for this apparent gap, including data capture errors. However, only 4% of SCLC patients received their chemotherapy within 14 days, which suggests data processing alone will not explain the underperformance. These findings have been consistent over a number of years and need a systematic investigation led by the Welsh Cancer Network to explain these findings. The static nature of these key performance indicators despite many improvement initiatives suggests that in addition to continuous improvement more radical changes are needed, e.g. lung health checks and rapid diagnostic hubs. Recovery planning after the pandemic would be an opportunity to trial some of these initiatives.

4.14.3 Areas of good practice and improvement

4.14.3.1 All Wales NSCLC genetics pathway quality improvement project

Introduction: All cases of locally advanced/metastatic non-small cell lung adenocarcinoma require biomarker testing at diagnosis to identify patients who may benefit from targeted therapy. In Wales, DNA and RNA NGS is routinely available via the All Wales Medical Genomics Service (AWMGS) within 14 days of sample receipt. The All Wales National Optimal Pathway (NOP) for Lung Cancer recommends genomics results are available within 10 days of biopsy.

Methods: Lung MDTs were invited to take part in a retrospective audit of the NGS pathway within Wales; data from patient records and laboratory information management systems were analysed to identify requesting patterns, turnaround times (TAT) and incidence of actionable variants.

Results: Data was submitted from 7 MDTs for 53 patients with NGS testing between October 2020 and May 2021. 40 (75.5%) patients had both DNA and RNA NGS, the remainder had

DNA NGS +/- FISH testing for ALK/ROS/NTRK gene rearrangements. Median TAT from biopsy to results for DNA and RNA NGS was 26 days and 25 days, respectively (figure 1); MDTs with reflex testing had shorter TAT. DNA NGS testing was successful in 51 (96.2%) patients; RNA NGS testing was unsuccessful in 10 (25%) patients however salvage FISH testing gave results in 7 cases. Testing identified clinically actionable variants in 17 (32%) patients.

Conclusions: In order to improve time to definitive treatment and patient outcomes, the diagnostic pathway TAT need to be reduced. The Welsh Thoracic Oncology Group plans to review the NOP to optimise and standardise genomic testing. Specifically the AWMGS has established a working group to facilitate implementation of a 7 day target for NGS results from time of sample receipt; priorities include increasing the number of NGS runs per week, increasing staff capacity for sample processing, result reporting and authorisation, and optimising DNA/RNA extraction methods to reduce testing failure rates.

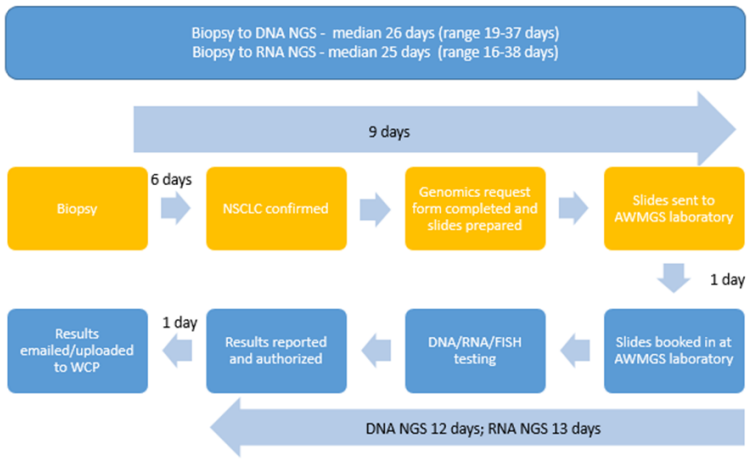


Figure 1: Median turnaround times for genomics pathway (where data available)

4.14.3.2 Macmillan Lung Cancer Pathway Evaluation

In interviews, staff and patients identified improvements in person-centred care because of the role. However, these improvements are mainly confined to patients from the two referral hospitals that the Macmillan lung cancer CNS supports. Factors such as staff capacity, staff attitudes and geography have been suggested as potential drivers behind this prioritisation of input.

Evidence of positive impacts on the delivery of person-centred care, e.g., acting as a key point of contact for patients on treatment at VCC, supports the continuation of the role. Staff to continue approach of empowering patient to choose which CNS to contact to practice person-centred care and alleviate any possible confusion for patients caused by access to multiple points of contact. Carry out further work to understand how the Macmillan lung cancer CNS' input has been prioritised across patients from local district hospitals and assess whether these decisions have been made in line with patient needs. Investigate whether ensuring equitable access to Macmillan lung cancer CNS support will improve quality in terms of health outcomes.

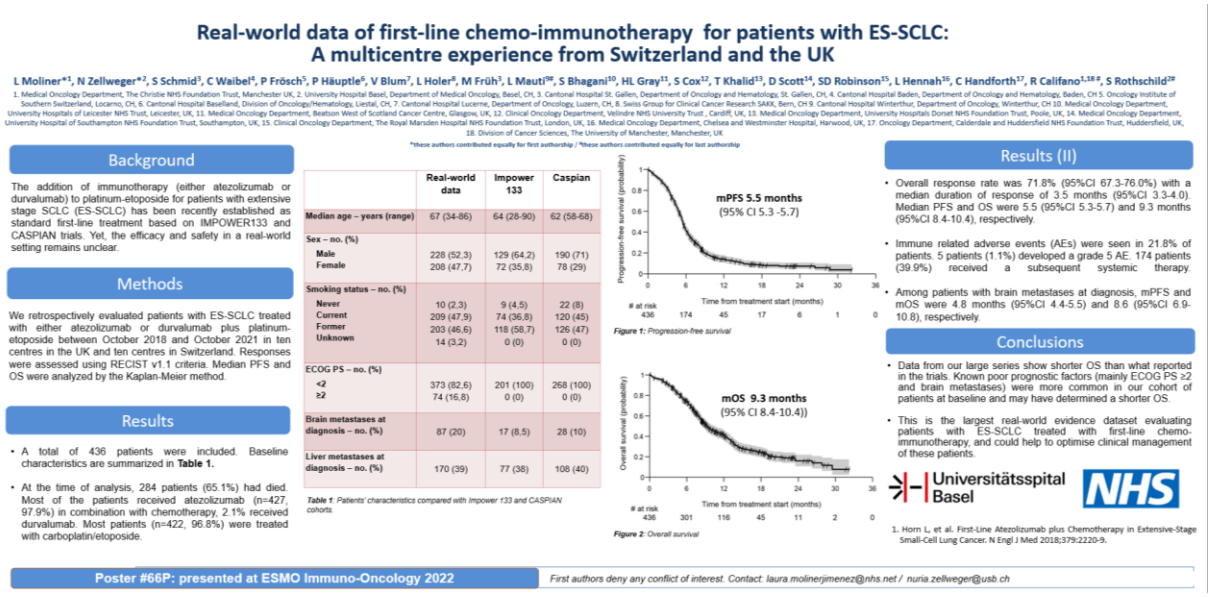
4.14.4 Posters and Publications

4.14.4.1 All Wales NSCL Genetics BTOG

4.14.4.2 Real-world experience of carboplatin/etoposide/atezolizumab for SCLC

Engagement with a national project which won the Best Poster Award (presented to lead author Laura Moliner, Manchester) at ESMO Congress 2022.

The data has also contributed to this poster submission (see attached) which took place at ESMO immuno-Oncology conference Dec 2022 – international collaboration.



Real-world data of first-line chemo-immunotherapy for patients with ES-SCLC: A multicentre experience from Switzerland and the UK

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Background

The addition of immunotherapy (either atezolizumab or durvalumab) to platinum-etoposide for patients with extensive stage SCLC (ES-SCLC) has been recently established as standard first-line treatment based on IMPOWER133 and CASPIAN trials. Yet, the efficacy and safety in a real-world setting remains unclear.

Methods

We retrospectively evaluated patients with ES-SCLC treated with either atezolizumab or durvalumab plus platinum-etoposide between October 2018 and October 2021 in ten centres in the UK and ten centres in Switzerland. Responses were assessed using RECIST v1.1 criteria. Median PFS and OS were analyzed by the Kaplan-Meier method.

Results

- A total of 436 patients were included. Baseline characteristics are summarized in **Table 1.**
- At the time of analysis, 284 patients (65.1%) had died. Most of the patients received atezolizumab (n=427, 97.9%) in combination with chemotherapy, 2.1% received durvalumab. Most patients (n=422, 96.8%) were treated with carboplatin/etoposide.

	Real-world data	Impower 133	Caspian
Median age – years (range)	67 (34-86)	64 (28-90)	62 (58-68)
Sex – no. (%)			
Male	228 (52,3)	129 (64,2)	190 (71)
Female	208 (47,7)	72 (35,8)	78 (29)
Smoking status – no. (%)			
Never	10 (2,3)	9 (4,5)	22 (8)
Current	209 (47,9)	74 (36,8)	120 (45)
Former	203 (46,6)	118 (58,7)	126 (47)
Unknown	14 (3,2)	0 (0)	0 (0)
ECOG PS – no. (%)			
<2	373 (82,6)	201 (100)	268 (100)
≥2	74 (16,8)	0 (0)	0 (0)
Brain metastases at diagnosis – no. (%)	87 (20)	17 (8,5)	28 (10)
Liver metastases at diagnosis – no. (%)	170 (39)	77 (38)	108 (40)

Table 1: Patients' characteristics compared with Impower 133 and CASPIAN cohorts.

Figure 1: Progression-free survival

Figure 2: Overall survival

Results (II)

- Overall response rate was 71.8% (95%CI 67.3-76.0%) with a median duration of response of 3.5 months (95%CI 3.3-4.0). Median PFS and OS were 5.5 (95%CI 5.3-5.7) and 9.3 months (95%CI 8.4-10.4), respectively.
- Immune related adverse events (AEs) were seen in 21.8% of patients. 5 patients (1.1%) developed a grade 5 AE. 174 patients (39.9%) received a subsequent systemic therapy.
- Among patients with brain metastases at diagnosis, mPFS and mOS were 4.8 months (95%CI 4.4-5.5) and 8.6 (95%CI 6.9-10.8), respectively.

Conclusions

- Data from our large series show shorter OS than what reported in the trials. Known poor prognostic factors (mainly ECOG PS ≥2 and brain metastases) were more common in our cohort of patients at baseline and may have determined a shorter OS.
- This is the largest real-world evidence dataset evaluating patients with ES-SCLC treated with first-line chemo-immunotherapy, and could help to optimise clinical management of these patients.

Universitätsspital Basel NHS

1. Horn L, et al. First-Line Atezolizumab plus Chemotherapy in Extensive-Stage Small-Cell Lung Cancer. N Engl J Med 2018;379:2220-9.

Poster #66P: presented at ESMO Immuno-Oncology 2022

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4.15 PALLIATIVE CARE SERVICE SPECIFIC TEAM

4.15.1 Palliative care Clinical Audit Activity

	Complete	Active	Discontinued	Onhold
2021/22	2	1	1	0
2022/23	4	1	1	0

**Figures exclude mandatory national audits and continuous monitoring*

4.15.2 National Audits and Continuous Monitoring

4.15.2.1 The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland. NACEL is an annual audit managed by the NHS Benchmarking Network, supported by the Clinical Leads, the NACEL Steering Group, and wider Advisory Group

Every year, over half a million people die in England and Wales, almost half of these in a hospital setting. Following the Neuberger review, More Care, Less Pathway, 2013, and the phasing out of the Liverpool Care Pathway (LCP), the Leadership Alliance published One Chance To Get It Right, 2014, setting out the Five priorities for care of the dying person. NACEL measures the performance of hospitals against criteria relating to the five priorities, and relevant NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

4.15.2.2 All-Wales Care Decisions for the Last Days of Life Audit was introduced widely across Wales in 2016. Since then, progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.

4.15.2.3 Palliative Care Outcome Scale (POS –S) audit is an evaluation tool with which we are able to assess the quality of care in palliative care patients. It assess a patient's physical, psychological and emotional symptoms, as well collecting information about their care and support needs. These measures are uniquely developed so as to be suitable for patients with chronic/life limiting diseases such as cancer, degenerative/neurological disease, respiratory and heart failure. These assessment methods can be used in the clinical environment, in audit, research and in training purposes.

POS-s is an additional assessment tool that focuses on symptom control. This measure is particularly useful when patients have multiple symptoms and is adaptable to all clinical settings; hospital, hospice or home setting. The measures have been shown to be sensitive to changes in a patient's condition over time.

4.15.3 Areas of good practice and improvement

4.15.3.1 Advance and future care planning: strategic approaches in Wales

Background: In Wales, the term advance care planning now falls under the wider umbrella term 'Future Care Planning', which also includes patients with diminished mental capacity and their significant others, to engage in deciding and planning future care. Over the last 5 years, work has been undertaken to create education formats, resources and national documents, and this has been informed by a national Advance and Future Care Planning steering group and national conference, which included patient and carer representatives. This helped collate relevant data.

Aim: We outline key strategic approaches in Wales with regard to future care planning.

Results: With data from our national conference and through feedback from stakeholders, a

national repository of distinct resources, forms and education formats has been created. The approach seeks to cater for the disparate need of the Welsh population; there is not merely one format for multiple scenarios, but a choice of approaches, communication strategies and documents to suit bespoke needs.

Conclusion: Advance and future care planning is an approach with many different facets. In Wales, we have found that some patients prefer a clearly set out, legally binding 'Advance Decision to Refuse Treatment' to guide their care, while others prefer a softer, guiding approach captured through an Advance Statement. All these formats are available to patients, carers and healthcare professionals, together with explanatory guidance notes, through a central Welsh website. Next steps involve getting a central electronic repository for these forms, which is accessible to healthcare providers and to patients

4.15.3.2 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit

This audit showed that the correct completion of forms was achieved over 95% of the time. The introduction of the new national form resulted in clearer documentation and communication of discussions that were held with patients and their significant others, as well as documenting reasons on rarer occasions when conversations could not take place.

Conclusion
Results show diligent completion of forms, with more information available in the second data collection, following introduction of the newest All Wales DNACPR forms and focused teaching sessions on this topic in the hospital trust. Next steps are ensuring these forms remain with patients, and are clearly communicated to all individuals involved in their care across acute and community settings. This is likely to be achieved most effectively and safely via a central electronic repository for advance and future care plans, which is accessible by all relevant healthcare providers and NHS Wales IT systems, as well as patients and their carers

Key messages

What was already known?

- Clear documentation of DNACPR decisions is important and forms and policies should encourage better communication.
- There is a 'duty to consult' with patients when a DNACPR decision is being made, in most cases, unless the individual lacks capacity or involvement may cause harm.

What are the new findings?

- The new All Wales DNACPR form and accompanying materials (patient facing videos, leaflets, all Wales policy) provide a clear way of documenting and communicating decisions about DNACPR and discussions that have happened with patients and their significant others.

What is the significance of this?

- The form enables important information to be documented and gives space to record (or make reference to) discussions surrounding the CPR/DNACPR communication and decisions.
- The form suggests full communication with patients, but also their next of kin, unless it is felt it may cause physical or psychological harm.

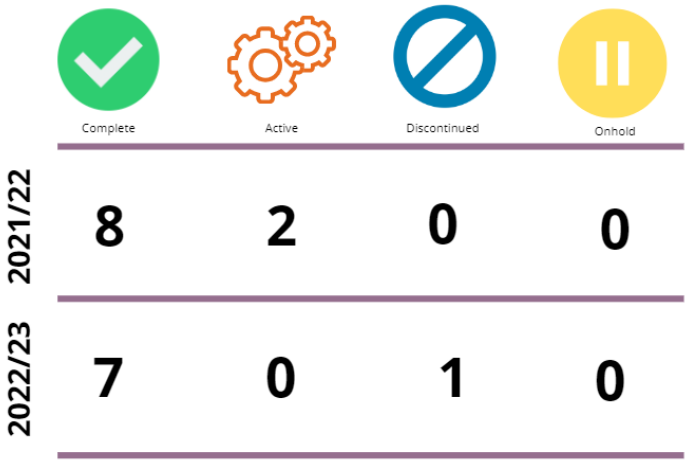
- Further work is required to ensure that these discussions and decisions, which in many cases were initiated by patients themselves, are adequately communicated among all healthcare professionals involved in a person's care.
- Future electronic patient records could be designed in such a way that the form cannot be completed without all sections (incl free-text segments) populated, for instance to describe the nature of the conversation with patient and nominated significant others. This cannot be done with paper records.

4.15.4 Posters and publications

Advance and future care planning: strategic approaches in Wales: BMJ 1st February 2022

4.16 UGI Site Specific Team

4.16.1 UGI Clinical Audit Activity



	Complete	Active	Discontinued	Onhold
2021/22	8	2	0	0
2022/23	7	0	1	0

**Figures exclude mandatory national audits and continuous monitoring*

4.16.2 National Audits and Continuous Monitoring

The National Oesophago-Gastric Cancer Audit (NOGCA) was established to investigate the quality of care received by patients with oesophago-gastric (OG) cancer in England and Wales. It aims to provide information for NHS cancer services so that they can benchmark their performance and identify areas where aspects of care could be improved. Around 13,000 people are diagnosed with OG cancer in England and Wales annually. It is the fifth most common type of cancer, and patients are often diagnosed with more advanced disease compared with other cancers.

NOGCA collects prospective data on adult patients diagnosed in England and Wales with invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach, or high-grade dysplasia (HGD) of the oesophagus.

Welsh data was provided by NHS Wales Health Collaborative. This dataset did not provide access to information on surgical complication rates, details of chemotherapy or radiotherapy regimens or on patients diagnosed with oesophageal HGD. Consequently, results requiring this data is not reported for Welsh patients**.**

4.16.3 Areas of good practice and improvement

4.16.3.1 An audit of emergency presentations and referrals of patients with oesophagogastric cancer

The results show that all patients that were submitted to NOGCA 2020 from AB and C&V health boards as emergency referrals were true emergencies. The way in which emergency referrals are recorded for submission to NOGCA are also accurate in AB and C&V health boards. The patients who were referred as an emergency from these health boards are accurately reflected in the NOGCA audit values. These findings suggest that there may be other contributing factors to the rate of higher emergency referrals in Wales in comparison to England, and that the issue is not to do with the way in which emergency referrals are recorded.

In conclusion, this audit seems to suggest that there are a few issues with the way in which emergency referrals are recorded in Wales for submission to NOGCA 2020. More research needs to be conducted in order to discover the reasons for why the emergency admissions and referrals rate is significantly higher in Wales compared to England.

One study conducted in the Netherlands to identify reasons for delays in cancer diagnosis, found that patients need to be educated on recognising the alarm symptoms of cancer, which can speed up the diagnosis process (7). Similarly, this may also be an issue in Wales, and more work needs to be done to identify any underlying problems that are causing life-threatening delays in the diagnostic process of oesophago-gastric malignancy.

4.16.3.2 An Audit of the Treatment Outcomes of Squamous Cell Carcinomas of the Middle and Lower Oesophagus

Early diagnosis of the disease is crucial for improving overall survival. Currently, there is regular screening of those with Barrett's oesophagus (a pre-neoplastic lesion) and those with chronic diseases who are deemed high risk. However, it has not been proven cost-effective and therefore, a regular screening programme has yet to be implemented [6]. Neoadjuvant treatment followed by surgery had the highest overall 5-year survival, but caution must be taken when interpretating this data due to the limited sample size. It is difficult to decipher from the literature which treatment is most successful overall as there has not been a head-to-head trial directly comparing outcomes of definitive CRT and surgery which are the 2 most common treatment options offered to patients. The difference in survival rates is multi-factorial and variance in patient age, gender, performance status, tumour stage and location will have an impact on overall survival. Further research into treatment options from trials is required to improve the survival rates amongst this population. Multi-modal combination therapy has been mentioned as a future treatment option which would combine surgery, chemotherapy, radiotherapy, targeted therapy and immunotherapy [13].

4.16.3.3 A Clinical Audit into the Outcomes of Radical and Palliative Patients Treated with Chemo-radio Therapy for Oesophageal Cancer

This study has looked at the survival outcomes in patients when being treated with either NACRT or peri-operative chemotherapy before radical surgery. It finds that the overall survival and progression free survival is higher when patients are treated with NACRT. In the UK, there are currently no guidelines as to which treatment is better and the decision is usually made by the patient. In the future, this research, alongside other studies, can provide evidence to show

an increased survival benefit of using NACRT. To continue this research, incorporate the tumour stage at diagnosis into the statistical analysis to remove other variables and improve accuracy in the survival outcomes. It is important to take into consideration that chemoradiotherapy may also have more adverse outcomes (10). Therefore, it is important to discuss with each individual patient and find out their preference as their quality of life is of high importance.

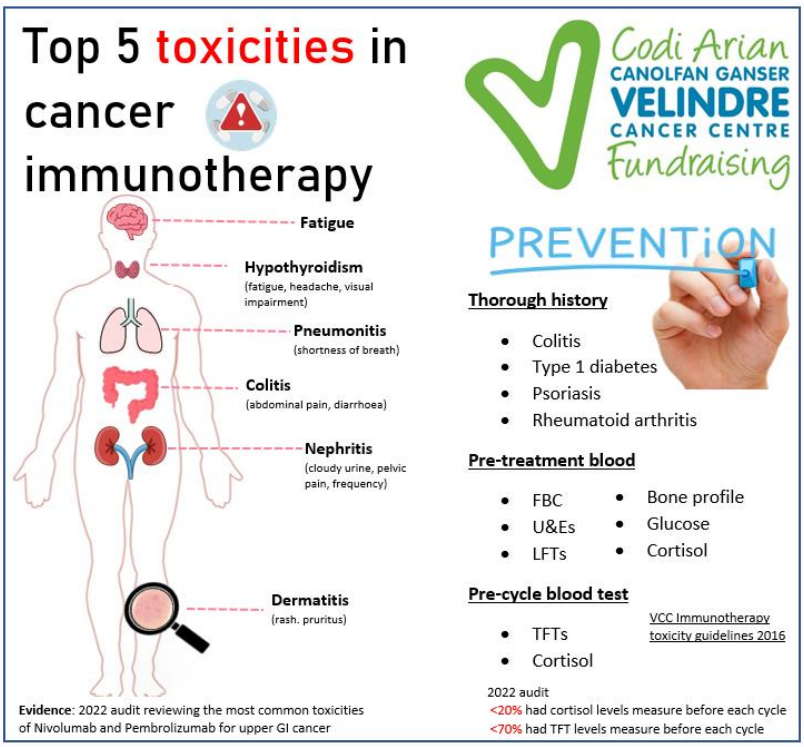
4.16.3.4 AUDIT- Identifying toxicities experienced during immunotherapy treatment for upper GI cancer and biomarkers measured before and during treatment

Evidence shows that endocrinopathy are amongst the most common toxicities experienced with immunotherapy use. Whilst most toxicities experienced are grade 1 or grade 2, life-threatening complications such as adrenal crisis, thyrotoxicosis and diabetic ketoacidosis can occur which are easily avoidable with routine blood test. The VVC toxicity guidelines emphasizes the importance of pre-cycle TFT and cortisol blood tests. Our audit shows that only an average of 70% of a patients total cycles TFTs blood test were taken and an average of 16% for cortisol. It was evident that FBC, LFTs, U&Es and bone profile are biomarkers in routine blood test. We suggest in order to prevent irreversible endocrinopathies, that pre-cycle blood forms should include cortisol, TFT and glucose as a routine. This in turn will reduce the incidence of toxicities but also reduce the number of patients having to take replacement therapies. As these replacement therapies have long-term effects such as high-dose glucocorticoids which can increase the risk of hypoglycaemia and osteoperosis.

Limitations of this audit included a small cohort size of 16. In the future, this research should be continued where analysis can be carried out on a larger data set. Alternatively, include other cancers that use Nivolumab and Pembrolizumab such as hepatocellular carcinoma. A larger cohort will provide more accurate information to identify the most common toxicities experienced on these therapies. In addition, it may become more evident what blood tests are most commonly missed. This will then allow to implement new guidelines that ensure the correct pre-treatment and pre-cycle blood tests are carried out.

In conclusion, our audit shows that nausea and vomiting are common toxicities experienced in patients on immunotherapies. Health workers should make patients aware of these symptoms. In addition, our results show that the required blood test pre-treatment and pre-cycle stipulated in the immunotherapy toxicity guidelines were not followed. Pre-cycle TFTs and cortisol levels were not measured at a target of 100% of the time. It is important that these tests are implemented into normal practice to reduce the risk of life-threatening toxicities.

The following poster outlines information for NHS staff, this poster has been modified for use in practice.



4.17 UROLOGY SITE SPECIFIC TEAM

4.17.1 Urology Clinical Audit Activity

	Complete	Active	Discontinued	Onhold
2021/22	9	0	0	1
2022/23	3	6	1	0

**Figures exclude mandatory national audits and continuous monitoring*

4.17.2 National Audits and Continuous Monitoring

Prostate cancer is the most frequently diagnosed solid cancer (over 40,000 new cases each year) and the second most common cause of cancer-related death in men in the UK. The National Prostate Cancer Audit (NPCA) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government with the aim of assessing the process of care and its outcomes in all men diagnosed with prostate cancer in England and Wales.

4.17.3 Areas of good practice and improvement

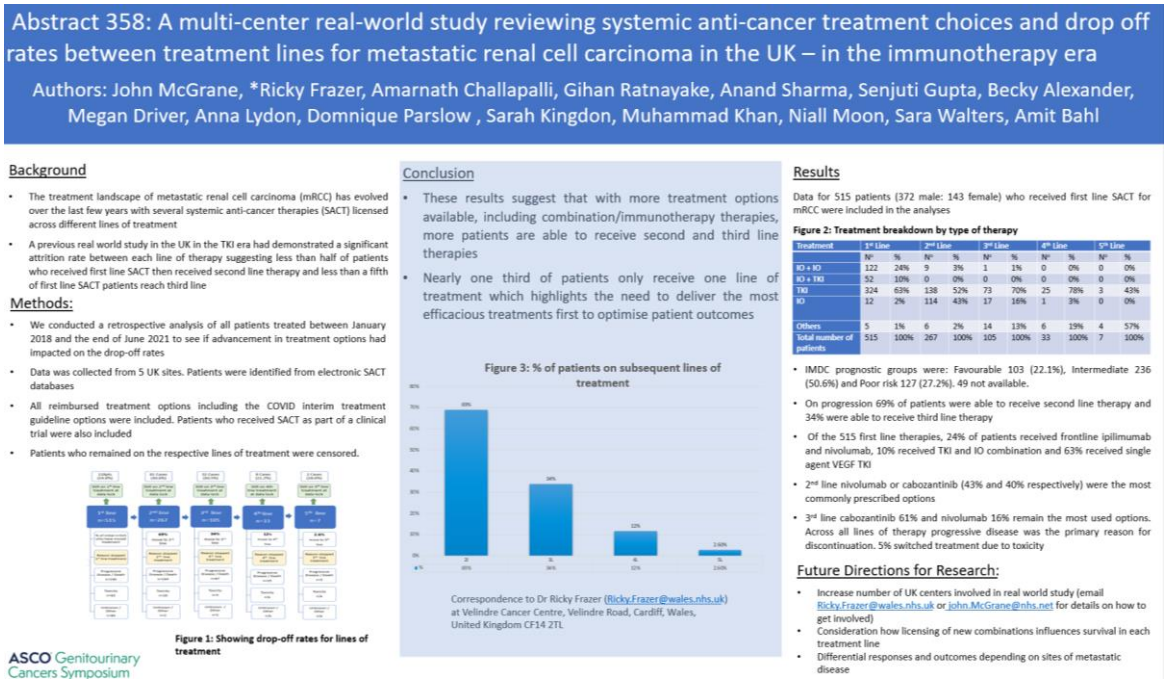
4.17.3.1 Patient survey

The majority of men were satisfied with their first consultation, discussion of treatment, concerns and needs and with the care they received from Velindre Cancer Centre. The majority of men were also satisfied with the information they received, however 23 patients wanted more information on possible side effects and 28 on fatigue. 25 did not feel equipped for living well after cancer diagnosis. 19 men were not provided with the Velindre CNS's contact details during their treatment in Velindre and only 20 patients offered HNA -all patients should be given contact of key worker and HNA. Over ¾ of the men felt that a written treatment plan would be beneficial. The majority of patients were satisfied with follow up in either OPD or telephone-no strong feelings towards either.

Recommendations:

- Navigator will continue to distribute team/key worker information to patients
- Navigator will also continue to offer patient opportunity to complete Holistic Needs Assessment (HNA) also promoting awareness of HNA's
- Formulate personalised care plan at 6 monthly radiotherapy follow-up appointment.
- Re-start education seminars
- Recorded videos of management of side effects and living well after cancer. To put into DVD format and QR code on radiotherapy patient leaflet to then distribute to patients
- Develop treatment plans to be sent out to patients and GP's post initial diagnosis
- Develop self management patient portal and PSA tracker

4.17.3.2 Renal cancer audit



Abstract 358: A multi-center real-world study reviewing systemic anti-cancer treatment choices and drop off rates between treatment lines for metastatic renal cell carcinoma in the UK – in the immunotherapy era

Authors: John McGrane, *Ricky Frazer, Amarnath Challapalli, Gihan Ratnayake, Anand Sharma, Senjuti Gupta, Becky Alexander, Megan Driver, Anna Lydon, Domnique Parslow , Sarah Kingdon, Muhammad Khan, Niall Moon, Sara Walters, Amit Bahl

Background

- The treatment landscape of metastatic renal cell carcinoma (mRCC) has evolved over the last few years with several systemic anti-cancer therapies (SACT) licensed across different lines of treatment
- A previous real world study in the UK in the TKI era had demonstrated a significant attrition rate between each line of therapy suggesting less than half of patients who received first line SACT then received second line therapy and less than a fifth of first line SACT patients reach third line

Methods:

- We conducted a retrospective analysis of all patients treated between January 2018 and the end of June 2021 to see if advancement in treatment options had impacted on the drop-off rates
- Data was collected from 5 UK sites. Patients were identified from electronic SACT databases
- All reimbursed treatment options including the COVID interim treatment guideline options were included. Patients who received SACT as part of a clinical trial were also included
- Patients who remained on the respective lines of treatment were censored.

Figure 1: Showing drop-off rates for lines of treatment

ASCO Genitourinary Cancers Symposium

Conclusion

- These results suggest that with more treatment options available, including combination/immunotherapy therapies, more patients are able to receive second and third line therapies
- Nearly one third of patients only receive one line of treatment which highlights the need to deliver the most efficacious treatments first to optimise patient outcomes

Figure 3: % of patients on subsequent lines of treatment

Correspondence to Dr Ricky Frazer (Ricky.Frazer@wales.nhs.uk) at Velindre Cancer Centre, Velindre Road, Cardiff, Wales, United Kingdom CF14 2TL

Results

Data for 515 patients (372 male: 143 female) who received first line SACT for mRCC were included in the analyses

Figure 2: Treatment breakdown by type of therapy

Treatment	1st Line		2nd Line		3rd Line		4th Line		5th Line	
	N°	%	N°	%	N°	%	N°	%	N°	%
IO + IO	122	24%	9	3%	1	1%	0	0%	0	0%
IO + TKI	52	10%	0	0%	0	0%	0	0%	0	0%
TKI	324	63%	138	52%	73	70%	25	78%	3	43%
IO	12	2%	114	43%	17	16%	1	3%	0	0%
Others	5	1%	6	2%	14	13%	6	19%	4	57%
Total number of patients	515	100%	267	100%	105	100%	33	100%	7	100%

- IMDC prognostic groups were: Favourable 103 (22.1%), Intermediate 236 (50.6%) and Poor risk 127 (27.2%). 49 not available.
- On progression 69% of patients were able to receive second line therapy and 34% were able to receive third line therapy
- Of the 515 first line therapies, 24% of patients received frontline ipilimumab and nivolumab, 10% received TKI and IO combination and 63% received single agent VEGF TKI
- 2nd line nivolumab or cabozantinib (43% and 40% respectively) were the most commonly prescribed options
- 3rd line cabozantinib 61% and nivolumab 16% remain the most used options. Across all lines of therapy progressive disease was the primary reason for discontinuation. 5% switched treatment due to toxicity

Future Directions for Research:

- Increase number of UK centers involved in real world study (email Ricky.Frazer@wales.nhs.uk or John.McGrane@nhs.net for details on how to get involved)
- Consideration how licensing of new combinations influences survival in each treatment line
- Differential responses and outcomes depending on sites of metastatic disease

4.17.3.3 Post Holistic Needs Assessment (HNA): Patient Survey urology

Prostate cancer is increasing in both incidence and survival rate with a long life expectancy for many men. There is a recognized high level of post treatment unmet need. Global consensus and National policies support the integration of holistic care of these patients at every stage of their care pathway. A recognised method of managing holistic health is through the use of a Holistic Needs Assessment (HNA) consultation which can inform the patient's care plan in a collaborative manner. The Clinical Nurse Specialist is often regarded as the person best placed to deliver HNAs but the role of the CNS has changed and often includes Non-Medical Prescribing (NMP). This change results in less time for supportive elements of the CNS role such as HNAs and despite the introduction of the HNA over 15 years ago, its implementation has been inconsistent and the number delivered locally is low.

Recognition of this has contributed to the introduction of support workers in a new role as Navigators to assist in provision of supportive care. The aim of this project was to implement and evaluate the impact of delivering HNAs as part of the new Navigator support worker role. It is proposed to increase the number of HNAs being offered to patients with metastatic prostate cancer who are receiving Systemic Anti-Cancer Treatment (SACT) within an NMP clinic. An Improvement Model was followed to provide a structure and a system for implementation of the HNA service. Patient experience was assessed through a questionnaire.

The project has found that HNAs can be implemented within a SACT service but this can only be realised with dedicated and protected staff, time and space. The Navigator role is important as a coordinator of the HNA process. The HNA information has potential benefits in service improvement if collected in an appropriate method. With appropriate resource, the HNA intervention can be used to reduce unmet need by providing health education and support.

4.17 3.4 Stereotactic Ablative Radiotherapy (SABR) Metastatic prostate

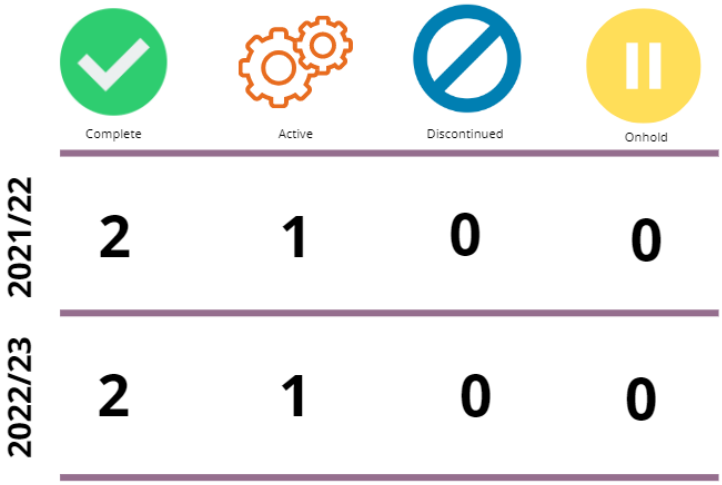
57 patients were reviewed; patients were diagnosed from November 2011 to November 2019 and Gleason scores ranged between 6 and 9. Initial radical treatments of the primary tumour included: prostatectomy, radiotherapy, neoadjuvant and adjuvant hormones, and LDR brachytherapy in varying combinations. 33 (57.9%) patients had oligometastasis in bone (situated in the spine, sacrum, pelvis and ribs in 15 (26.3%), 2 (3.5%), 12 (21.1%) and 4 (7%) patients respectively), 26 (45.6%) in lymph nodes and 2 (3.5%) in both. At time of SABR, 33 (57.9%) patients were not on ADT. For these patients, the median time to initiating ADT post-SABR was 23 months (15.6 - 30.4). Median time to PSA rise post-SABR was 14 months (9.8 - 18.2). Median time to biochemical failure was 23 months (15.0 - 31.0). Local control was 100%. 3 (5.3%) patients died.

This review has found encouraging results: excellent local control, prolonged time to biochemical failure and subsequent ADT use with mild toxicities as the only downside to the SABR approach which is preferable to ADT side effects many patients wish to avoid. Collating evidence from this review and previous studies allows the conclusion that SABR is a promising management approach for men with oligometastatic PCa who wish to prolong their time to starting ADT. As a curative treatment method, SABR alone may or may not be sufficient, however it's possible that the combination of SABR with hormonal therapies may provide the attack required to cure this disease. Further investigation is required to provide support for this rationale.

The project showed excellent practice which is always reassuring especially as it is a relatively new technique. No areas identified as needing improving.

4.18 NEURO-ONCOLOGY SITE SPECIFIC TEAM

4.18.1 Neuro-Oncology Clinical Audit Activity



	Complete	Active	Discontinued	Onhold
2021/22	2	1	0	0
2022/23	2	1	0	0

**Figures exclude mandatory national audits and continuous monitoring*

4.18.2 National Audits and Continuous Monitoring

There are currently no national audits within this site

4.18.3 Areas of good practice and improvement

4.18.3.1 Stereotactic radiosurgery (SRS) and Stereotactic radiotherapy (SRT) for brain metastases: a multi-discipline single centre case series assessment of toxicities and outcomes.

Results: 266 SRS treatments were delivered to 225 patients. Of the 266 treatments delivered, 224(84%) were initial treatments and 37(14%) were second treatments. 51(23%) patients also had whole brain radiotherapy. The most common primary sites were lung (42%), melanoma (18%), Breast (16%) and renal (9%). 159(60%) of 266 treatments delivered were for a single brain metastasis and 79(30%) for 2 metastases. 27(13%) included treatment for post-operative tumour bed boost. Patients were most commonly prescribed 21Gy/1# (63%). 34(13%) included fractionated treatments. Median total PTV volume was 5.69 cm3 (range 0.09-26.83) for single fraction treatments and 14.96 cm3 (range 1.15-47.28) for fractionated treatments. 13(5%) treatments included Total PTV >20cm3. Most (8) were <24cm3 and included fractionated treatments. For SRS, V12Gy correlated with PTV with correlation coefficient 0.723.

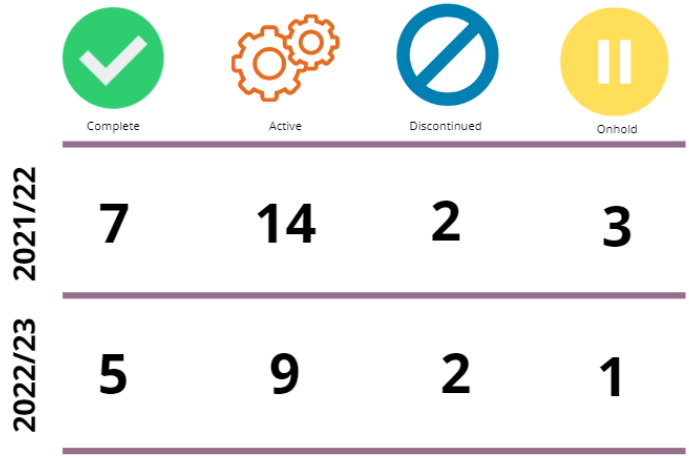
Toxicity was measured prospectively during radiographer led telephone consultations at predetermined endpoints (first and final fraction, week 1 and 6, month 3 and 12). The most common acute toxicities were grade 1-2 and included fatigue, headache and memory impairment. Grade 3 toxicity at 3 months consisted of, fatigue (n=3, 1.3%), hearing loss (n=1 0.4%), and blurred vision (n=1, 0.4%). All grade 3 toxicity had resolved by 12 months post SRS. There were no grade 4 toxicities.

Median overall survival of the 225 patients treated in the cohort was 335 days. The 6-month and 1-year survival rate was 65.0% and 46.2% respectively. Large PTV Volume (>15cm3) correlated with worse mean survival.

Conclusion: Large overall PTV volume remains an important predictor of outcome. SRS and SRT are well tolerated and effective treatment options to improve intracranial disease control for patients with brain metastases. Future studies could include subset analysis of the cohort based on tumour sub-type and V12Gy could provide further information with respect to patient outcomes. Limitations in the project include uncertainty in assessing rates of relapse, rates of radionecrosis, and cause of death outcomes. Abstract submitted to - BNOS conference

4.19 OTHER SITES AND SERVICES

4.19.1 Other Sites and Service Clinical Audit Activity



**Figures exclude mandatory national audits and continuous monitoring*

4.20 Consent

Written documentation of informed consent is required for SACT treatment which has a number of significant and potentially life threating toxicities. An audit was undertaken in 2018, to assess the standard of documentation of SACT consent before and after the introduction of new consent forms in the breast team. This audit identified areas for improvement and it was recommended that an audit of all sites and treatments requiring consent was undertaken.

A task and finish group was re-established to discuss the recommendations from the consent audit. The group decide that in order to understand the extent of some of the issues identified in the previous audit, a re-audit of all patients who received both SACT and Radiotherapy should be undertaken. All patients who received either SACT or radiotherapy during the first 2 weeks of November 2021 were reviewed. This data was retrieved from the data warehouse.

A total of 364 patients were reviewed, 21 were removed from the analysis as it was identified in the previous audit that non SACT treatments such as denosumab do not require a consent form to be completed. However, it is worth noting that 81% of patients had a consent form for these treatments present in the notes. The audit demonstrated the standards set out by the UK Chemotherapy Board guidance for SACT consent were not met. There have been improvements in a number of areas but there is still work to been done in order to achieve the required standards. There has been an increase in the use of CRUK and RCR forms within

the cancer centre, however consent form 1 is still being used in nearly half (45%) of cases. The results will be feedback to the consent task and finish group and an action plan will be developed.

A number of changes have been implemented; Staff have been informed to stop using the VCC consent forms and have been instructed to use the CRUK forms for SACT, RCR forms for radiotherapy and the All Wales consent forms for everything else (PICC etc). A dedicated consent page on the intranet with a link to CRUK and RCR has been established and the All Wales consent forms have been circulated to all departments.

It has been recommend that all professionals who undertake consent are to complete an ESR module 000 NHS Wales – Decision Making and Consent in Wales. Work is also being undertaken to incorporate consent into the junior doctor induction.

The consent form policy will be updated with the changes and once ratified will be available on the consent intranet page

A re-audit has been scheduled for June 2023.

4.21 Chaperone audit

A total number of 275 patients' records were reviewed of which 149 had an intimate examination documented in Canisc. On review of the notes there was no documentation regarding an offer or acceptance of a chaperone in any of the notes reviewed, however there was mention of a chaperone being present, their job title and patients consent to being examined in some cases.

Of the 31 (21%) patients that had a chaperone present, the name and designation of the chaperone was present in 81% (25/31) of cases. The audit demonstrates areas for improvement in all the key elements within the good working principles.

An action plan was developed as a result of the audit and a number of the recommendations have already been implemented. Posters have been designed and put up around the outpatients department. SST leads and CNS's have been made aware if the guidelines through attendance at various meetings. A re-audit has been planned for the next financial year.

4.22 Mortality

4.22.1 Deaths within 30 days of Chemotherapy

A revision of the existing all Wales Core Cancer Minimum Reporting Requirements together with the development of new Site/Patient Group Specific Cancer Minimum Reporting Requirements was necessary to ensure Wales has effective, efficient and timely world-class healthcare information to provide intelligence and the insight to drive healthcare service improvements.

The capture and monitoring of deaths within 30 days of SACT has been mandated since the NCEPOD report of 2008. Peer review of Welsh SACT services in 2020 revealed

inconsistencies in the reporting of this data. The collection and subsequent review of deaths within 30 days of SACT enables learning and development of high quality services.

Therefore death within 30 days of SACT is now a reporting requirement within the new Systemic Anti-Cancer Therapy (SACT) Clinical Quality Performance Indicators.

Method

Death within 30 Days of SACT is defined as 30 days from the first day of the SACT cycle immediately prior to death. When SACT is given continuously, then the 30 day period is defined as death within 30 days of the date of the last prescription.

In general, SACT is given in cycles. SACT may be a single drug or a combination of drugs. A cycle may be considered as either a single delivery, delivery of treatment over several consecutive days, or a continuous treatment.

Numerator / Denominator

- **Numerator for Treatment Intent Curative:** Total number of curative patients who died within 30 days from the first day of a cycle of SACT
- **Denominator for Treatment Intent Curative:** Total number of patients receiving SACT who have curative treatment intent.
- **Numerator for Treatment Intent Palliative:** Total number of palliative patients who died within 30 days from the first day of a cycle of SACT
- **Denominator for Treatment Intent Palliative:** Total number of patients receiving SACT who have palliative treatment intent.

Inclusions:

1. Patients aged 18 years or over.
2. All patients who died within 30 days from the first day of a cycle of receiving SACT, either in hospital or in the community.

The following list of drug types defined as SACT for the purpose of this quality performance indictor:

- Cytotoxic
- Drug-antibody conjugates
- Immunotherapy
- Monoclonal antibody
- Neoangiogenesis Inhibitor
- Radio-sensitiser
- Tyrosine kinase inhibitor

Results

Death within 30 days of Radical SACT for April 2023

Breakdown by month

Month	Radical SACT	Radical Deaths	%
October 2022	782	4	0.5
November 2022	758	2	0.3
December 2022	726	2	0.3
January 2023	776	2	0.3
February 2023	777	1	0.1
March 2023	803	2	0.3

Death within 30 days of Palliative SACT for April 2023

Figures for March 2023

Breakdown by month

Month	Palliative SACT	Palliative Deaths	%
October 2022	1014	15	1.5
November 2022	1013	14	1.4
December 2022	1026	11	1.1
January 2023	1019	10	1.0
February 2023	1088	8	0.7
March 2023	1180	8	0.7

4.21.2 Deaths within 30 days of Palliative

Radiotherapy and 90 days of Radical Radiotherapy

The Radiotherapy Dataset (RTDS) standard requires all NHS providers of radiotherapy services in England and Wales to collect and submit standardised data monthly against a nationally defined dataset. There has been a revision of the RTDS Dataset to V6 and also in the Welsh Radiotherapy (RT) Clinical Quality Performance Indicators. The change requires the collection of 30 day mortality following palliative radiotherapy and 90 day mortality following radical radiotherapy

The collection and subsequent review of deaths within 30 days of palliative intent RT and 90 days of curative intent RT enables learning and development of high quality services. It is a clinical indicator of transparency in outcomes and protecting patients from avoidable harm

No nationally agreed standard currently exists; however, this data will enable us to benchmark results against published data from other centres moving forward.

It should be noted that we currently working to determine the definition of "radical" as it pertains death within 90 days. Radical is commonly taken to mean cases where the patient is expected to be cured, but sometimes patients are treated with radiotherapy regimens thought of as radical in dose/ fractionation, when they are not expected to be cured. This has resulted in variability as to how different clinicians classify the same patients and may impact upon figures in this report compared to subsequent reports when the definition is clarified. We have contacted the Royal College of Radiologists and other NHS bodies to ensure our reporting is consistent with the approach across the UK.

Methodology
Death within 30/90 Days of Radiotherapy - is defined as death within 30 days from the first day of the radiotherapy episode exposure given prior to death. When radiotherapy is given continuously, then the 30-day period is defined as death within 30 days of the date of the first exposure in that episode. The first day of an exposure to radiotherapy (episode) is classed as day 0.

Calculation of % death rate = No of deaths within 30/90 days of first fraction of radiotherapy divided by total number of courses of radiotherapy over the same time period x 100.

Findings
A number of issues were identified when undertaking the analysis of this data that requires clarification from a clinical perspective.

1. A number of patients received both radical and palliative treatments within the time period. Need to ascertain if both treatments should be included or the last treatment. i.e. palliative intent
2. There are patients that have a palliative diagnosis but are receiving a radical dose of radiotherapy and therefore are classed as radical treatment intent within the dataset i.e. neuro-oncology treatment. Need to understand which dataset they should be included in.
3. Clarification as to if emergency and urgent symptom control should be included in the palliative treatment intent or excluded from the data

It is worth noting that the figures below will vary depending on the decisions made regarding the data set and the inclusion/exclusion criteria noted above.

Death 30 days Palliative Radiotherapy

Figure 1. demonstrates death within 30 days of palliative radiotherapy during April 2023 and includes both emergency and urgent care patients.

The Welsh Radiotherapy (RT) Clinical Quality Performance Indicators request monthly data, breakdown per month is detailed below.

Month	RT	Deaths	%
October 2022	125	10	8.0%
November 2022	99	13	13.1%
December 2022	89	13	14.6%
January 2023	85	6	5.9%
February 2023	105	9	8.6%
March 2023	104	5	4.8%

Death 90 days Radical Radiotherapy

Figure 2. demonstrates death within 90 days of radical radiotherapy and includes both scheduled and elective delay; these were reviewed and the majority were identified as radical intent

The Welsh Radiotherapy (RT) Clinical Quality Performance Indicators request monthly data, breakdown per month is detailed below.

Month	RT	Deaths	%
October 2022	225	3	0.9%
November 2022	210	7	2.0%
December 2022	183	5	1.6%
January 2023	253	3	1.2%
February 2023	239	3	1.3%
March 2023	291	5	1.7%

4.22.3 Mortality and Morbidity meetings

It was identified as part of the SACT peer review that a more robust approach to death within 30 days of SACT was required. A working group was established, and it was agreed to pilot a M+M meeting in one Site Specific Team (SST) to understand how the process would work in practice and to identify any issues prior to rolling out across the cancer Centre. The colorectal SST volunteered to be the pilot site, with the focus of the meeting being primarily educational and to improve patient care. The meetings are to be delivered in a supportive and confidential manner and should be conducted by the multidisciplinary team involved with the patients care. The pilot identified issues that needed addressing before the roll out to other sites. This includes the need for a standalone meeting, a digital form and also identifying who is responsible for completing the forms. The pilot will be extended and reviewed again.
As part of Duty of Candour a standardised assessment to any potential adverse outcomes to patients, and if unexpected or untended harm did occur following SACT or RT, is required. The M & M meeting would provide assurance to VCC that all deaths within 30 days of chemo and 90 days of RT where considered in light of NHS Wales legislations and Duty of Candour triggered if appropriate.
The pilot has been extended addressing the issues identified. This included

- Scheduling a standalone meeting for the M&M reviews instead of including as part of the SST's agenda. Other staff involved in the patients care should be invited to participate in discussions and a representation from another SST to provide additional scrutiny.
- Designing the mortality form on AMaT and trial the completion before and during the Meeting
- Identifying the responsible person for the completion of the review prior to mortality and morbidity meeting. This could be rotated through the SPR, the responsibility of the consultant or a team response.
- Clarifying the roles and responsibilities for mortality and morbidity within the organisation and the reporting structures, in particular the process for escalation and actioning of outcomes from the reviews.
- Trust requirements regarding mortality; should the M+M reviews be a mandatory requirement for each SST, with clinical staff engagement in the process reviewed at annual appraisal.

5.0 WELSH BLOOD SERVICE SUMMARY

5.1 Foreword

The Welsh Blood Service (WBS) provides compatibility testing and other diagnostic services related to blood, cellular therapies and organs. The WBS also collects cells for cellular therapies and blood components, which are provided along with medicines derived from plasma, some drugs and vaccines to the NHS in Wales and also to other countries.

There are many synergies for the two operational divisions of the Trust. Bone marrow and stem cells are predominantly supplied by the WBS for the treatment and cure of cancers. 25-30% of blood components are provided as part of the supportive treatment for patients with cancer. More blood components are transfused in the Velindre Cancer Centre than some general hospitals in Wales. The stem cells for treating cancers and other disorders are collected in the Velindre Cancer Centre site.

Despite the challenges of the pandemic, with changes in the way we provide existing services, and the addition of new services such as the national distribution of COVID vaccines, clinical audit has continued to be performed to assure the governance of the organisation. The WBS contributes to international audit and performance monitoring through UK 4 nation, European and wider international initiatives in all areas. These include the Serious Hazards of Transfusion haemovigilance scheme for patients and donors, The UK Health Security Agency (UKHSA) Infectious Diseases Annual Surveillance Report and European Blood Alliance bench marking surveys.

A cycle of audit and other work in the field of pre-operative anaemia contributed to the award of Value Based Health Care funding to implement improvements across Wales. Significant change in eligibility criteria for blood donation were successfully implemented in Wales as demonstrated by the audit of For Assessment of Individualised Risk (FAIR) enabling previously excluded individuals to donate safely.

Audit of the appropriate use of these services internally for our own patients and across Wales are an important part of assurance for the Trust. Unlike VCC the WBS does not have staff specifically employed to support or undertake audit other than the generic requirement in the job descriptions and job plans of staff in clinical roles to participate in audit.

Key points that need addressing

- Enablement of a consistent trust wide culture of innovation, learning, improvement and clinical audit to support the provision of safe, effective, person centred care provision.
- Provision of Clinical Audit support across both divisions.
- The potential for improved integration of audit, quality and service improvement in quality improvement hubs
- Limited opportunities to disseminate and showcase work within the Trust, especially in the absence of an integrated audit team
- The need to adapt a whole system approach that enables collaborative working both with all Health Boards and Trusts across Wales, and internally within our own departments.

The development of Quality and Safety Hubs enables further focus on this. It will be particularly important to have an integrated Clinical Audit Team with the Trust and a synergistic Trust wide 3-year plan as opposed to separate divisional audit plans.
The audit activity has been presented to reflect the operational areas of the WBS:

1) Blood Health: Meeting the needs of patients with blood components
2) Blood Donor Care: To support donors in meeting the needs of patients for blood.
3) Laboratory diagnostic and therapeutic support to patients requiring blood transfusion
4) Meeting the needs of transplant recipients, providing compatibility testing for donors and recipients of stem cell and organ transplants. Supporting donors in donating cellular therapies in the Trust.

Edwin Massey
Medical Director Welsh Blood Service

5.2 Blood Health audits and performance indicators (ensuring that patients who are likely to benefit receive a blood transfusion and those unlikely to benefit do not)

5.2.1 Blood Health key performance indicator monitoring April 1st 2021- March 31st 2023
The Blood Health National Oversight Group (BHNOG) has developed key performance indicators (KPIs) for a range of transfusion metrics. The data provides an ongoing audit tool of practice from each of the HBs in Wales. All data is shared across Wales to encourage transparency, learning and discussion of best practice. These have been collated and produced by the WBS on a monthly or quarterly basis throughout the two

5.2.1.1 Appropriate Use of O D negative (universal blood group) red cells and audit of blood components used in major haemorrhage (MH): Monthly dashboards provide ongoing audit of:
a. O D negative as a percentage of total red cell issues (KPI 12%)
b. O D negative wastage as a percentage of O D negative red cells issued (KPI 10%)
Quarterly audits are also completed for all major haemorrhage protocol activations (MHPs) across Wales to promote appropriate use and monitor use of O D positive red cells for males and females who do not have childbearing potential (defined as over 50 years old) thus keeping stocks of O D negative for females of childbearing potential who need them.

5.2.1.2. Appropriate use of platelets: Monthly dashboards provide ongoing audit of platelet wastage (KPI 15%). Quarterly audits are also completed for platelet wastage within the Welsh Blood Service facilities with a more stringent KPI of 10% than the 15% set for Health Boards. Importation of platelets to Wales from other UK nations is also reported. These reports are submitted to the BHNOG for scrutiny. Recent amendments to stock holding practice have led to an improvement in wastage within the WBS, achieving the KPIs required.

5.3 Blood Health Audits

5.3.1 Pre-operative anaemia audit (and subsequent Value Based Health Care funding)

Anaemia has been identified as a key work stream for the BHNOG. In 2020 a baseline audit of the management of preoperative anaemia was undertaken showing that only 50% (9/18) of hospitals in Wales had a preoperative anaemia process. The Welsh Perioperative Medicine Society (W-POMS) identified leads for preoperative anaemia in each Health Board and an All-Wales Pre-operative Anaemia Pathway was produced (https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2022/01/All-Wales-Pathway-Final-Version-2.pdf).

A follow up audit was undertaken in 2021 to assess impact of the implementation of a pre-operative anaemia pathway for patients across Wales.

In June 2021, all 18 hospitals (100%) from the 6 Health Boards in Wales (not including Powys which does not have acute hospitals and outsources this work) agreed to use the All-Wales Pre-operative Anaemia Pathway. Benchmarking data against the agreed pathway demonstrated significant improvements in consistency and compliance across Wales.

94% (15/16) hospitals were using Haemoglobin (Hb) >130g/L for all patients and serum ferritin and/or transferrin saturations (TSATs) for anaemia identification in line with the new pathway. Only 47% of TSATS and 18% of ferritin results were provided on the same day however limiting the prospect of same day iron treatment.

88% (14/16) used intravenous (IV) iron for first line treatment of iron deficiency anaemia prior to urgent surgery in line with the All-Wales pathway. The same applied for the use of oral iron as first line treatment for iron deficiency for elective surgery scheduled for more than 12 weeks.

Summary and subsequent progress:

Full implementation of the pathway would allow same day treatment during the pre-assessment visit to minimise hospital appointments. The audit identified barriers to implementation including test turnaround times, the ability to review results and staff/ facilities to provide IV iron are examples of reasons why it has currently been implemented with varying success in health boards across Wales.

A national testing process was agreed to identify the majority of patients that would benefit from iron treatment. Wales benefits from a national laboratory information management system (LIMS), which allows utilisation of standard blood sample test-codes, reflex testing and data extraction for audit purposes.

This work including the audit cycle was instrumental in obtaining Value Based Healthcare funding from the Welsh Government to support the full implementation of the pathway across Wales

5.3.2 Intraoperative Cell Salvage audit 2021 – 23 ongoing audit reported annually.

Intraoperative Cell Salvage (ICS) is a technique for collecting and processing blood shed during surgery with a view to reinfusing the red cells back into the patient. This intervention and the resultant autologous transfusion is a significant blood conservation measure. Like pre-operative anaemia *ICS has been made a key BHNOG workstream. An* All-Wales ICS Network (AWICSN) had been put in place with clinical leads in each Health Board, WBS staff collate and report on ICS usage across Wales. 1690 episodes of ICS usage were reported in 2021-22 which increased to 2038 reported episodes in 2022-23.

70% of ICS use (n=1435) was in an elective setting, 24% (n=492) in an emergency setting and in 6% (n=111) neither was specified. The specialty with the highest proportion of ICS use in the emergency setting was Obstetric at 51% (n=256/506); General and Vascular were next highest at 28% (n=35/125) and 27% (n=29/108) respectively.

The AWICSN plan to develop clear denominator data for surgical activity across the Health Boards have made amendments to the data collection process to improve the quality of data

and facilitate the introduction of performance indicators. This will help ensure equitable provision of ICS and improved monitoring of the appropriate use of ICS.

5.3.3 NICE Quality Standards: QS138 audit relating to NICE Guidance (NG) 24: Blood Transfusion. September 2022

In 2016 the National Institute for Health and Care Excellence (NICE) issued Quality Standard 138, to support the implementation of the Nice Guidance NG24, Blood Transfusion. In September 2022 all Health Boards (HBs) in Wales completed an audit of NICE Quality standards 138.
Standard QS138 is made up of 4 quality statements. These quality statements and the relevant findings of the All Wales audit are summarised below:

- People with iron-deficiency anaemia (IDA) who are having surgery are offered iron supplementation before and after surgery. There appeared to have a good level of compliance, better than that reported in the rest of the UK. This good performance will have been influenced by the work on pre-operative anaemia documented above.
- Adults who are having surgery and expected to have moderate blood loss are offered tranexamic acid. The documented level of compliance at 51%, appeared not to be as good as the UK data 68% but it was identified that auditors in Wales had difficulty accessing the records and hence there would be under-reporting. Use of tranexamic acid in elective surgery has now been included in the surgical checklist and it is anticipated that this will increase the use of tranexamic acid routinely. Improved accessibility to data on usage for auditors has been explored and this will be reassessed at follow up audit.
- People are clinically reassessed and have their haemoglobin levels checked after each unit of red blood cells they receive, unless they are bleeding or are on a chronic transfusion program. This appeared to have a poor level of compliance, (38% & 40% respectively) in Wales compared to the UK data where 65% and 70% compliance respectively was observed. This is clearly an area of concern and will be a priority area for further work and follow up. The All Wales Transfusion Record and transfusion associated circulatory overload assessment process has been updated to facilitate this
- People who may need or who have had a transfusion are given verbal and written information about blood transfusion. Provision of verbal and/or written information regarding transfusion has a very poor level of compliance; with 26% of patients in the NCA UK data receiving both verbal and written communication compared to 4% in Wales receiving both and 30% receiving verbal only. This is another area of concern for practice in Wales. The All Wales Transfusion Record update included clear statements on consent and a section to document consent.

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5.3.4 An all Wales audit of compliance with national guidance on platelet transfusion in patients with haematological disorders, 2022.

This re-audit was performed to assess compliance across Wales with the British Society for Haematology (BSH) guidelines for platelet transfusion. Improvements were seen in all areas when compared with performance against the same standards in a UK wide National Comparative Audit in 2017. There was 100% compliance with three out of 5 standards. .
The audit did identify additional work that needs to be completed in terms of wording of local guidance in Health Boards for greater clarity and consistency with national guidelines. This work is underway.

5.3.5 Blood Components Request Form Audit 2022

The All-Wales Transfusion Request Form was revised in 2021 to incorporate the National Blood Transfusion Committee (NBTC) indications for transfusion and associated coding. In 2022 an audit of the revised form was undertaken to provide baseline data on the uptake of this new functionality. The audit report demonstrated that while the reason for transfusion was hand written in the document and where relevant the haemoglobin concentration prior to red cell transfusion or platelet count prior to platelet transfusion were given there was poor compliance with the use of the new codes further defining the reason for transfusion.
The WBS Blood Health Team are working with Health Boards to increase familiarity with the codes and hence compliance across Wales.

5.3.6 Where Do Red Cells Go? Snapshot Audit, September 2022

Red cell transfusion use was audited in four of the largest HBs for the 4-week period defined. It was measured against similar audits undertaken in 2019 & 2021. This audit was to help us understand the distribution of red cell usage across Wales and identify any changes by specialty. Oncology and haematology remained the largest user at 27.6%, in terms of total numbers of red cells used, oncology, haematology, medicine and A&E had returned to total usage levels greater than seen pre-pandemic in 2019 whereas surgery, obstetric and overall usage remained below 2019 levels.

5.3.7 All Wales National Comparative Sample Labelling Audit 2022

The safety of the blood transfusion process depends on accurate patient, sample and blood component pack identification at all stages of the process. This starts crucially with the positive identification of the patient from whom the compatibility testing sample is taken. Errors can occur because a blood sample is incorrectly collected or mislabelled. The audit identified where /how and who errors most commonly occur. The audit was completed by all HBs in Wales, data appears to have changed very little since the last audit in 2010. A pilot service improvement project has been commissioned with a pilot HB.

5.3.8 Audits of education provided to medical students and postgraduates

a) Specialty Registrar (SpR) Education Programme Audit 2021
An audit of SpR training delivered in September 2021 was undertaken. As a result of this audit significant changes were made to the programme which will be audited again in 2023. This has provided further impetus to plans to develop a rotating registrar program into the transfusion subspecialty of haematology as otherwise exposure to this field of practice is limited and predominantly provided in a theoretical setting.

b) Senior Student Assistantship (SSA) audit 2022
The SSA programme is a well-established educational transfusion programme delivered to all final year medical students across Wales. The audit showed excellent feedback from students on the workstations delivered.

5.4 Blood Donor Care Audit

5.4.1 For the Assessment of Individualised Risk (FAIR) implementation review / audit

The English, Welsh and Scottish Blood Services implemented the FAIR recommendations on 14 June 2021. FAIR recommended moving the focus of donor eligibility assessments away from donors declaring risks associated with membership of population groups at higher risk of transfusion transmissible infections, for example men who have sex with men (MSM), to focus on an individual risk assessment based on an individual donor's lifestyle choices and behaviours. The FAIR changes and their implementation were covered widely by Welsh media, were well received amongst the Welsh Blood Service (WBS) staff and donor population and were favourably recognised and commented on by the Welsh Government.

A review / audit of the impact of implementation was undertaken by Dr Stuart Blackmore a year after FAIR was implemented:

Synopsis of Outcomes

Appointment uptake more than doubled on Monday (14 June). More than 1,750 donors booked to donate following coverage spread across BBC Wales, ITV Wales and local outlets across the country.

Compared to the previous Monday, inbound calls rose to 287 calls with 105 bookings – this compares with a daily average of 171 calls and 53 bookings. A further 264 bookings were made from Donor Contact Centre SMS and online registrations for new donors rose from 14 to 91 enrolments.

There were 70,000 social media accounts reached across social media on the day – setting a record for the most successful June for this measure – this is 50 000 above the daily average.

A full review was also carried out to analyse the success of the campaign during National Blood Donor Week. Over **235,000** accounts were reached during the week which is 130 000 above the weekly average.

12 months on

The Welsh Blood Service does not record information about sexual orientation on donors, so we are not able to provide any analysis about frequency of attendance of specific donor groups since introducing the FAIR changes. However the WBS can report that through monitoring social media channels and talking to donors on session, the WBS has been supported by members of the LGBTQ+ community since introducing the changes.

Donor Health Questionnaire:

FAIR introduced four new questions into the donor health questionnaire (at WBS this is called the Self Assessed Health History or SAHH), replacing the questions that identified donors at increased risk of having a transfusion transmissible infection based on their membership of certain population groups e.g. MSM.

During the period 14 June 2021 – 13 June 2022 a total of **90 585** SAHHs were completed and the numbers of donors answering "yes" to the 4 new FAIR questions are detailed below (all these donors would have had the appropriate deferral applied to their record):

Number of positive responses:	FAIR question on the SAHH
16	Have you ever had Syphilis and/or have you had a sexually transmitted disease in the last 3 months (including gonorrhoea)?
5	Have you had chemsex in the last 3 months? Chemsex often occurs in groups and involves the use of stimulant drugs (excluding cannabis, alcohol and Viagra) to enhance the sexual experience
713	In the last 3 months have you had more than 1 sexual partner AND/OR a new sexual partner?
24	Have you had anal sex in the last 3 months with or without a condom or other protection?

Transfusion Transmissible Infections (TTI):

The following table details the numbers of donors diagnosed with a confirmed transfusion transmissible infection for the 3 years prior to FAIR implementation and for the first year thereafter.

The rise in the number of donors with confirmed syphilis is notable but this aligns with the rising prevalence of syphilis in the general population and the rising prevalence amongst the Welsh blood donor population prior to FAIR implementation. There is no evidence of an overall increase in the number of viral TTIs post FAIR implementation.

Year	HTLV*	HBV*	HCV*	HIV*	Syphilis
14 June 2018 – 13 June 2019	0	0	2	1	2
14 June 2019 – 13 June 2020	0	0	2	0	3
14 June 2020 – 13 June 2021	0	2	1	0	7
14 June 2021 – 13 June 2022	0	1	0	0	10

* Human T lymphotrophic virus, Hepatitis B virus, Hepatitis C virus, Human Immunodeficiency Virus.

Compliments/Concerns:

No significant donor complaints have been received by the WBS regarding the implementation of FAIR. Specifically, there have been no complaints from donors who are no longer eligible to donate but were eligible prior to the introduction of the FAIR changes.

One member of staff raised religious based concerns during FAIR training prior to the launch of FAIR. These were appropriately addressed to the satisfaction of the staff member prior to launch.

Numerous compliments were received by the WBS from various individuals and organisations, including the Welsh Government post FAIR implementation.

In summary, the implementation of FAIR has been well received by donors, staff, fellow NHS organisations and the general public. WBS are now proud to have a donor eligibility assessment tool which assesses an individual's risk of having a TTI based on their personal lifestyle choices and be

haviours rather than their membership of a subpopulation at increased risk of TTIs.

5.4.2 Audit of the impact of the addition of Hepatitis B core antibody (anti-HBc) testing to blood donor screening tests

A review was undertaken 1 year after implementation. This is reported in greater detail elsewhere (via the Trust management to the Welsh Government Delivery and Oversight Board) but it is summarised here.

The WBS started testing all donations for anti-HBc from 27 May 2022. After 1 year (26 May 2023) the WBS had tested 83 443 donations – testing every donor every time. Some donors had returned more than once and have therefore been tested more than once but in total we have tested 50 228 donors, 66.17% of the regular donor base of 75 907

122 donors have been confirmed as anti-HBc positive. A further 12 have had repeatedly inconclusive anti-HBc screening tests (an expected finding in screening).

3 donors have been identified as having occult hepatitis B infection (OBI) with detectable HBV DNA either in the fresh sample from their first anti-HBc test on return to donation or from a retrieved and defrosted stored archive sample

Lookback: initially WBS performing lookback on recipients of components from donors who fall into the Safety of Blood Tissues and Organs (SaBTO) advisory committee categories 1 and 2 but not the lower risk categories 3 and 4.

Three donors from SaBTO categories 1 and 2 were identified who had donated 80 blood component packs which had been issued to hospitals to transfused to patients:

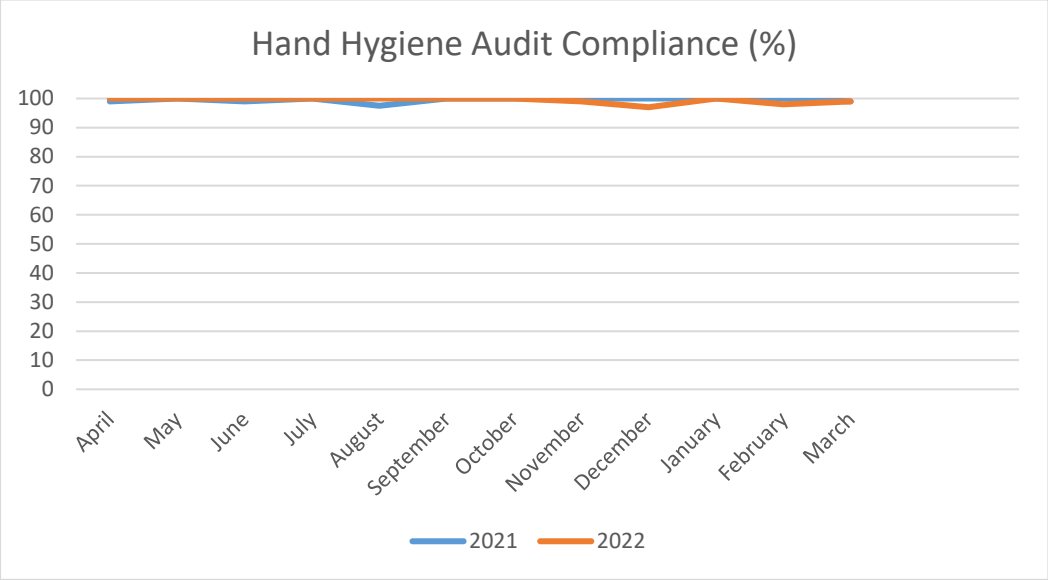
	Number of Components Issued			
	Red Cells	Platelets	Plasma	Total
Donor 1	43	4	13	60
Donor 2	12	2	2	16
Donor 3	4	1	0	5
Total	58	7	15	80

The lookback is ongoing but to date no transmissions of infection historically have been detected and the additional safety measure of the screening test has been implemented successfully.

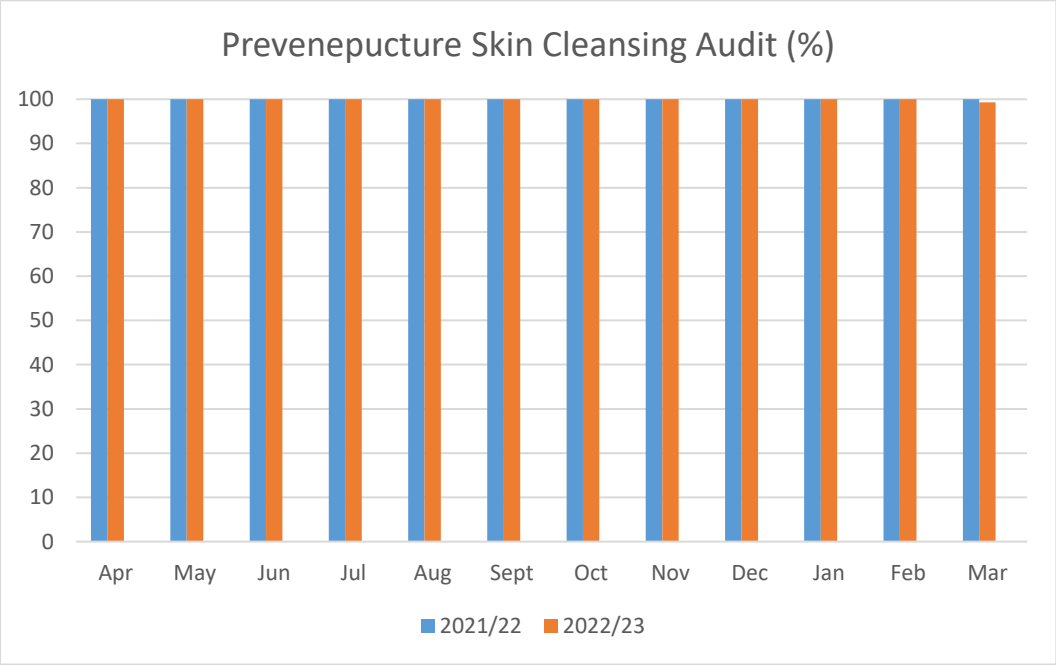
5.4.3 Infection prevention and control (IPC)

Effective hand hygiene and adequate skin cleansing practices are critical in ensuring the safety of donors and recipients. Therefore, WBS have implemented a robust monthly audit programme to ensure that required practices and standards are maintained. During 2021 - 2023 compliance within all donor facing services across Wales remained high.

Hand Hygiene

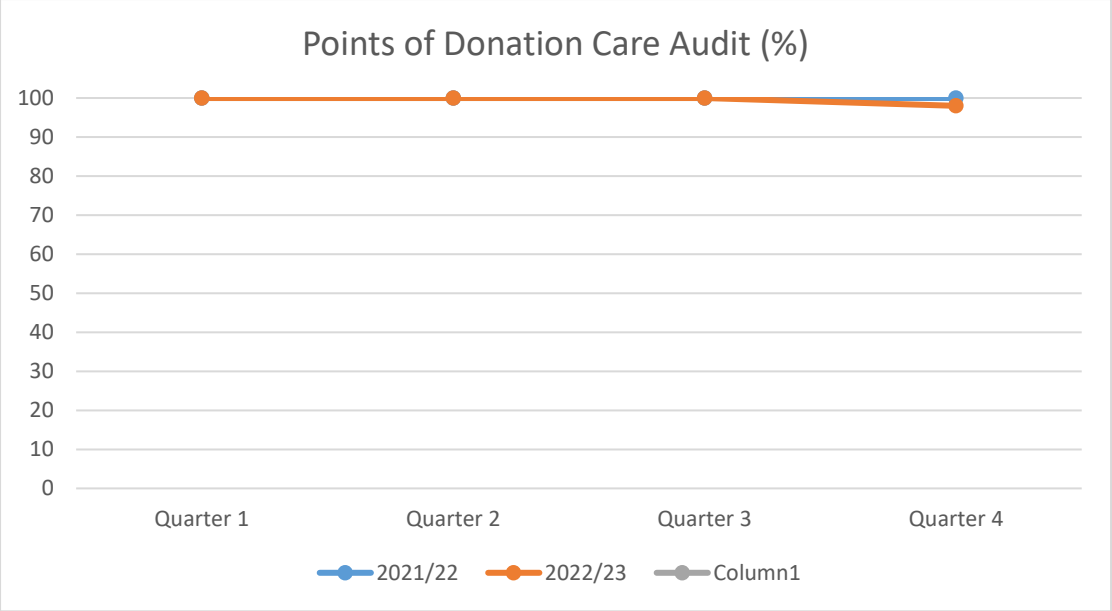


Pre-venepuncture skin cleansing



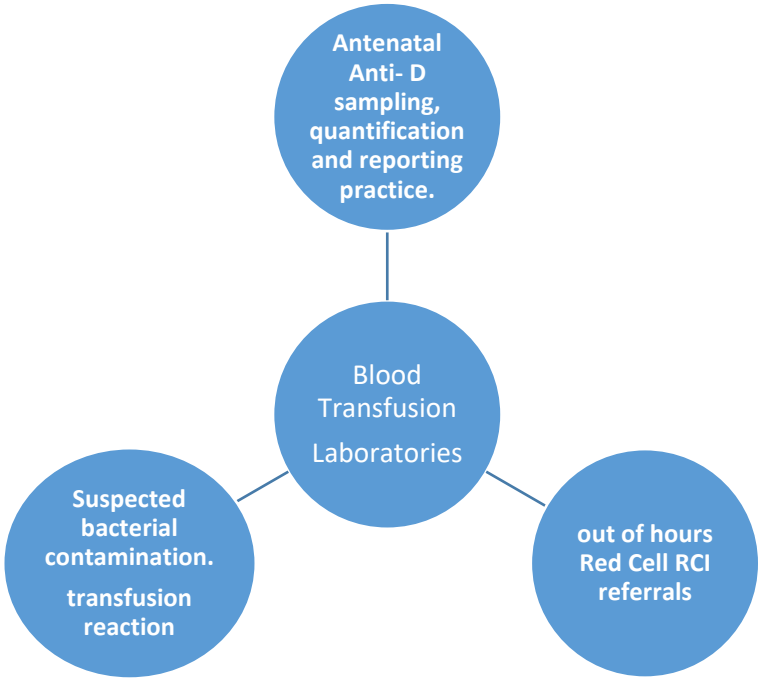
5.4.4 Blood Donor Points of Care Audit

To ensure that donors across Wales receive a safe, effective and equitable standard of care and experience the Welsh Blood Service undertakes a monthly evidence-based points of care audit to ensure that key aspects of donor care are delivered effectively, safely and consistency, throughout this reporting period compliance to the required standards across Wales have remained consistently high.



5.5 Clinical Audits in the WBS Blood Transfusion Laboratories

A range of Clinical Audits are undertaken across laboratories in WBS to ensure appropriate and safe processing and supply of blood and blood components and its prudent usage across NHS Wales. Such audits include:



5.5.1 Audit of antenatal anti-D sampling, quantification & reporting practice, 2021

Antenatal anti-D testing is part of a series of interventions to prevent or minimise the impact of haemolytic disease of the foetus and new-born (HDFN). The WBS red cell immunohaematology (RCI) laboratory serves as a reference laboratory for antenatal anti–D testing for all health boards across Wales.

The audit assessed compliance with the British Society for Haematology (BSH) 2016 guidelines for blood grouping and red cell antibody testing in pregnancy. The Royal College of Pathologists audit template was used. 996 referred samples were audited.

Compliance with the recommendation that samples for measuring anti-D are taken prior to the administration of anti-D prophylaxis (to detect maternal antibodies rather than detect the administered donor derived anti-D present after administration), was poor across Health Boards in Wales at 25.5%. Significant information was not disclosed to the RCI laboratory on the referral form accompanying the samples.

The RCI laboratory was also not fully compliant with BSH guidance:

A project group was established to rectify these areas of non-compliance recommendations working closely with midwives, obstetricians and laboratory staff across Wales.

- The audit findings were presented to obstetricians and midwives at a foetal medicine conference to increase the awareness of the foetal medicine teams on anti D testing
- The foetal medicine guidelines were updated taking into account the findings of the audit with direct input from the WBS
- A letter was sent to consultant haematologists, and transfusion laboratory managers informing changes in practice
- A letter was sent to all Obstetric consultants and trainees in Wales alerting them to the updated guidance published on the WISDOM (Welsh Information for Dissemination of Obstetrics & Gynaecology Materials) website.
- These messages were disseminated to midwives in Wales via the antenatal coordinators.
- Midwifery training was updated through close collaboration and this collaboration has enabled the development of additional training via this route ready for the implementation of non-invasive testing for foetal D type which the Welsh Blood Service anticipates implementing in 2024.
- The antenatal testing request form was reviewed and updated
- The method of reporting of anti-D results in the WBS reference laboratory was updated incorporating a flow chart for clarity. RCI reports are now fully compliant with BSH standards.

5.5.2 An audit of out of hours Red Cell Immunohaematology (RCI) referrals

A gap between the number of biomedical scientists training in the UK and the number of retirements / leavers / vacancies has been recorded for many years with publications also detailing a reduction in numbers of substantively employed staff with experience in blood transfusion. This would be anticipated to increase the number of samples referred to reference laboratories such as the WBS RCI laboratory who are also affected by the same issue in terms of numbers of experienced biomedical scientist staff.
100 samples referred to the WBS RCI laboratory out of hours were assessed for their appropriateness in terms of need for transfusion. The timing of the referrals and subsequent transfusion of the blood components provided was assessed as it is safer to undertake complex work during standard laboratory hours when there is a full complement of experienced staff.

- 88% (88/100) of the referrals resulted in the blood being transfused
- 33% of transfused units where the timing of transfusion was available were transfused > 3 hours of the on-call period ending suggesting that the work could have been performed during standard laboratory hours

- 42/100 (42%) of patients referred had been referred on more than one occasion OOH, with the maximum number a single patient had been referred during the audit timeline being nine times. This suggested that many out of hours referrals could be planned better enabling testing in hours.

The audit was presented to the transfusion laboratory managers across Wales and the following actions were taken

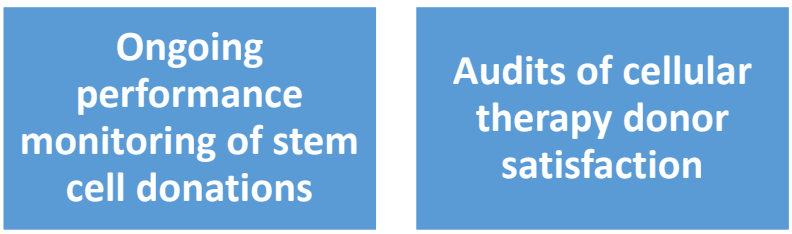
- The RCI referral forms (RS036/RS206) were updated to better capture the appropriateness of transfusion e.g. the patients' Hb, diagnosis and reason for transfusion
- In multidisciplinary collaboration with hospital staff, guidance on the following has been developed:
    - when it is appropriate for referrals to be made to RCI OOH
    - when medical consultants both within the hospital and Welsh Blood Service should be contacted by their respective laboratories
    - Transport for urgent samples and measures to reduce delays
    - A procedure to inform WBS consultants of patients who are repeatedly crossmatched OOH so that preventative plans can be put in place
- The recommendations were implemented in the form of Plan, Do, Study, Act (PDSA) cycles where the impact of the changes can be measured and reaudited

5.5.3 A reaudit of investigations for suspected bacterial contamination transfusion reactions at the Welsh Blood Service 2021

The success of the actions taken following a previous audit in 2019 was assessed by this reaudit of the quality of the information received with the referral, and the quality and timeliness of the report provided following the investigation by the WBS. British Society for Haematology guidance was used as the source of standards. The Royal College of Pathologists audit template was used.

The reaudit demonstrated improvements in most standards but further improvement could be seen in the detail provided with referrals by hospital staff and while the quality and consistency of the WBS reports was good the turnaround time had not improved.
The audit findings were fed back to hospital and WBS staff and steps have been taken to further improve in the identified areas. A further reaudit of these areas will be undertaken to confirm ongoing improvement.

5.6. Audits of support provided by the Trust to transplant recipients and donors.



5.6.1 Ongoing performance monitoring of stem cell donations

Continuous clinical audits are performed of stem cell collection efficiency, CD34+ cell count in stem dell donations and engraftment data is obtained from recipient centres. Donors are followed up to identify any pre and post donation issues. These are monitored against

international standards and the data is reviewed in our own internal clinical governance / Quality and Safety structure and by the regulators. Performance was satisfactory throughout this period despite challenges in provision as a result of the pandemic.

5.6.2 Audits of cellular therapy donor satisfaction

WBMDR nursing staff undertook audits to assess the satisfaction of donors with the information and counselling they received prior to donation and with the donation process itself.

The responders all scored 5 / 5 that they were completely satisfied with their care. Positive comments were received about the quantity and quality of the information they were provided in relation to the donation process. All stated that they would recommend donating to others.

5.6.3 Audits of aseptic non touch technique, donning and doffing, hand hygiene and personal protective equipment use by cellular therapy nursing staff undertaking collections in the Velindre Cancer Centre

100% compliance was demonstrated for cellular therapy collection in the Velindre Cancer Centre for all the infection prevention and control measures.

APPENDIX 1
Velindre Cancer Centre
Clinical Audit Project Progress

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
Medical Directorate								
National Audits								
6.2	National Audit of Breast Cancer in Older People	National audit to assess the management of all symptomatic and screen detected breast cancers.	Clinical Audit Dept.	National Audit	NABCOP 2022 Annual Report NABCOP-2021-Annual-Report			Ongoing (Annual)
3.1	National audit of lung cancer	The National Audit focuses on four main areas relating to lung cancer; the number of lung cancer cases within the UK, the range of treatments used, regional variations in these treatments and variations in outcomes	Clinical Audit Dept.	National Audit	Summary of Results for Patients Diagnosed in Wales 2021 NLCA State of the Nation Report 2023 NLCA Annual Report 2022	Areas of good practice Areas for improvement		Ongoing (Annual)
3.1	National Prostate Cancer Audit	Looking at diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes.	Clinical Audit Dept.	National Audit	NPCA Annual Report 2022 NPCA Annual Report 2021			Ongoing (Annual)
3.1	NOGCA - National Oesophago-gastric Cancer Audit	To evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.	Clinical Audit Dept.	National Audit	NOGCA 2022 Annual Report NOGCA_2021-Annual-Report		SACT and RT data not available for patients treated in Wales	Ongoing (Annual)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	National Bowel Cancer Audit	The Audit's main aim is to improve the quality of care and survival of patients with bowel cancer.	Clinical Audit Dept.	National Audit	NBOCA Annual Report 2022 NBOCA Annual Report 2021		SACT and RT data not available for patients treated in Wales	Ongoing (Annual)
3.1	UK National Audit of Care at the End of Life (NACEL) Audit	NHS Benchmarking project	SPCT	National Audit	NACEL Third round report 2021/22 NACEL Second round Report	N/A	We are participating in the next UK wide scheduled audit and evaluation and Mark Taubert is leading on this	Ongoing
	RCR Curative & N/A RT for Lung	To provide confirmation that there has been progress and allow a re-assessment of where further pieces of work need to be directed	Clinical Audit Dept. Mick Button	National Audit	Data Collection	N/A	N/A	Ongoing
Continuous Monitoring – Quality and Safety and Must Do's								
3.5 4.2	Consent Audit (Including Audit of all Wales consent form 4 (best interests)	To identify if consent form 4 was used appropriately and ascertain completeness	Clinical Audit Dept.	Clinical risk	The audit demonstrated the standards set out by the UK Chemotherapy Board guidance for SACT consent were not met. The audit enforced the need to look at the current process for how consent forms are stored. A number of patients had no consent form in their paper or electronic notes and therefore no evidence of written consent. There were a number of consent forms used within Velindre, the use of the All Wales form, which is also bilingual was very low. Clarity on which forms should be used is needed	Area for improvement	Need to identify current practice with regards to how consent forms are processed to ensure their inclusion into the electronic medical record and identify the gaps. Clarify which consent forms should be used Provide education/training around the use and completion of the consent forms.. Future aspirations to implement electronic consent. Annual audit Designated clinical lead for consent	Complete Annual

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1 3.5	Death within 30 days SACT	Review patients who die within 30 days of SACT	Clinical Audit Dept. SST's	Patient safety	Ongoing monthly/quarterly data collection	Areas for improvement	MM pilot underway in the colorectal team to review all deaths within 30 days of SACT and 30 days of palliative RT, 90 days of radical RT.	Ongoing (Monthly)
3.1	Mortality reviews	Review inpatients who die at Velindre.	SCIF Clinical Audit Dept.	Patient safety	Ongoing monthly review	N/A	N/A	Ongoing (Weekly)
3.1 3.2 4.1 6.2	Palliative Care Outcome Scale (POS –S) audit	Evaluation of the use the POS-S system compared to the National guidelines	Mark Taubert	National	Recommendation from last year's evaluation was to continue Hard-POS_S evaluation but may be worth doing every 2 years rather than each year	N/A	N/A	Ongoing (every 2 years)
Breast Malignancies SST								
3.1	Breast cancer radiotherapy and secondary cancer		Consultant Medical Student SSC	Key indicator of practice SSC Project	No SSC uptake and no resource within the team	N/A	N/A	Discontinue
3.1	The impact of the COVID pandemic on our breast cancer patients	To review new patient referrals made to the hospital over a 3 month period prior to the pandemic compared with the stage at which patients are referred following the pandemic There is a concern that patients have been at a more advanced stage of the cancer and are less fit now and are therefore able to have less treatment since the pandemic	Consultant Medical Student SSC	Key Indicators of Practice SSC Project	A higher proportion of advanced breast cancers were seen amongst the post-COVID cohort. The immense pressure the NHS faced during the pandemic meant that breast screening, imaging and management was delayed, Long term outcomes from these delays are yet to be determined, However, from this audit we can conclude that this may have had a significant impact on the stage and thus prognosis of breast cancer patients	Area for improvement	In the event of another surge in COVID-19 cases, prioritisation of screening programmes and maintaining accessibility to imaging and management warrants consideration as an option for mitigating delayed cancer diagnoses and hence prognosis improvement. Wider capacity for provision of services in order to tackle the	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
							backlog should also be considered.	
3.1	Primrose a national prospective observational study in breast cancer patients with central nervous system involvement in the UK	To report the survival of patients diagnosed with Central Nervous System (CNS) disease secondary to Breast cancer (BC).	SpR	NICE Guidelines/ National project	Data Collection stage	N/A	N/A	Active Proposed completion date April 2023
3.1	Altra - A national multi-centre audit of long term trastuzumab use in metastatic breast Cancer	National project to assess the long-term use of trastuzumab	Consultant SpR	National audit	Data submitted, awaiting National report	N/A	N/A	Complete
3.1	Audit of neutropenic septic admissions and dose delay/dose reductions with FEC100-T adjuvant and neoadjuvant chemotherapy given with pegfilgrastim	This audit completes the audit cycle a previous audit was performed looking at neoadjuvant chemotherapy and neutropenic septic rates and admissions/dose delay and dose reductions	SpR Consultant	Key Indicators of Practice	Project lead left the organisation and there is no resource to complete the project.	N/A	N/A	Discontinue
3.1	Review of Oligometastatic Patients Treated with Stereotactic Ablative Therapy (SABR)	The aim of the project is to update and build upon the existing SABR database so that we can evaluate our treatment and compare to benchmark.	Consultant Medical Student SSC	Key Indicators of Practice SSC	The findings of this audit support conclusions of the CtE evaluation report alongside other larger studies on SABR in OM patients. SABR is an effective treatment for OM patients with improved prognosis compared to standard	Area of good practice	Continue to populate database and collate PROMS and toxicity data	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					therapies. Velindre survival outcome and local control data is reassuring in line with data published through Commissioning Through Evaluation in England.			
	First line Capecitabine and Phesgo in MBC	To compare the outcome of capecitabine/phesgo first line in MBC with trial results PHEREXA.	SpR	NICE Guidance/ Clinical Risk	Awaiting report - waiting for the median follow up duration. Aim to submit it for UKBCG which would be open in November	N/A	N/A	Complete
	National Service Evaluation project, evaluating the "Safety and Efficacy of Atezolizumab in combination with *nab*-Paclitaxel	Participation in National Service evaluation to review safety and efficacy of atezolizumab with nab-paclitaxel in advanced triple negative breast cancer	Consultant SpR	NICE Guidance	Missed national deadline for submission	N/A	N/A	Discontinued
6.2	Tolerability of Ibrance (Palbociclib) in combination with an aromatase inhibitor in women 75 years ER+ve/ HER2-ve) metastatic breast cancer.	Real world toxicity and efficacy data is required, in an older UK population, to ensure that Ibrance (in combination with an AI) for first line treatment of metastatic oestrogen positive breast cancer is comparable to published trial data	Consultant	National project	Fourteen cancer centres from across the UK participated in this study with data collection completed in February 2021. 276 patients met the eligibility criteria. The median age of patients was 78 (range 75>92) years. Palbociclib is an effective therapy in the real-world older population and is well-tolerated with low levels of clinically significant toxicities.	Area of good practice Areas for improvement	The use of geriatric and frailty assessments can help guide decision making in these patients.	Complete
3.1	The response rate of Systemic Treatment in HER2 positive Brain Metastases	To review the chemotherapy given and the response rate within the brain in HER2 positive metastatic breast cancer patients.	Consultant SSC Project	Key indicator of practice Benchmarking	HER2 targeted therapy does have an effect on intracranial metastases. Therefore, there must be some changes to the BBB	Area of good practice	For future studies, a lot more patient data needs to be collected in order to get more reliable results which can be applied to	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	in secondary Breast Cancer				meaning that these drugs can pass.		clinical practice. More lab research identifying how the drugs reach the BM may be useful in understanding their mechanism of action which could be applied to new future therapies.	
	Evaluation of the BAPS app	Our aim was to standardise information given to patients post breast surgery in a more interactive fashion, empowering patients with an understanding of why the exercises are important, motivating them to achieve their goals in their own home and optimising the patient care pathway from surgery to radiotherapy. The BAPS app was launched in February	Physiotherapist CAD	Users/ Patient views Innovation	In October 2021 - 50 Questionnaires were distributed to patients who were undergoing RT with a 54% response rate. Only 41% of responses were aware of the baps app. 64% of these were told about it by their breast care nurse. 30% of these patients actually used the baps app post surgery	Areas for improvement	Need greater advertising of the baps app to widen use. Need to revise the inspirational hold element of the app.	Complete
	CDK4-6 inhibitors during the COVID-19 pandemic – administration, safety & outcomes. Real world data from the UK.	To explore the safety of CDK4-6 inhibitor therapy for advanced breast cancer patients during the COVID-19 pandemic	Consultant	National project	This project will be discontinued. National data has been published and therefore too late for data submission.	N/A	N/A	Discontinued
3.5	Re-audit ER/HER2 misreporting	To re-audit the documentation and accuracy of ER/HER2 status	Clinical Audit Dept.	Incident	In total the records of 1145 were reviewed, and no error in treatment were identified. There has been a significant improvement in the availability of source data within WCP, principally the histopathology results for patients diagnosed through the screening service at	Areas of good practice Areas for improvement	Reminder to whole MDT that treatment plans should not be made without sight of the source pathology results. Post pandemic, increasing numbers of patients are being diagnosed with breast cancer in the	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					Breast Test Wales. Limitations of the CMDS function in Canisc means that ER/HER2 are not recorded as a set field making interrogation of data difficult,		Private sector, then subsequently treated in the NHS. These results are not available in any accessible portal and this is a potential risk. Currently results must be scanned into Canisc, Regular audit to monitor documentation	
Gynaecological Malignancies SST								
3.1	Outcomes from image guided brachytherapy	To review outcomes of patients receiving Brachytherapy.	Consultant Medical Student SSC	Key indicator of practice	3D conformal radiotherapy ± chemotherapy plus image (MRI) guided adaptive intracavitary brachytherapy including needle insertion in advanced disease results in local control rates of 95–100% at 3 years in limited/favourable (IB/IIB) and 85–90% in large/poor response (IIB/III/IV) cervix cancer patients associated with a moderate rate of treatment related morbidity. Compared to the historical Vienna series there is relative reduction in pelvic recurrence by 65–70% and reduction in major morbidity. The local control improvement seems to have impact on CSS and OS.	Area of good practice	N/A	Complete
3.1	Royal College of Radiologists (RCR) National audit of Vulva Cancer follow-up	To provide follow up information with regards to patients outcomes and toxicity	CAD Consultant	National Audit	34 UK radiotherapy centres (63%) completed data entry with 152 patients. 23 out of 34 (68%) centres submitted follow-up data, with 94 patients. The targets of radical radiotherapy reached 96% for the elective volumes and boost	N/A	After publishing the audit results and national vulvar cancer contouring guidelines, we will repeat the cycle.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					doses by 59%, and 54% for radical radiotherapy with concurrent cisplatin. Adjuvant radiotherapy with the RCR fractionation was 96% for the elective volume and 39% for the target volume. Other targets achieved were 26% for gap compensation, 84% for IMRT, 77% for category 1			
6.3	Late Effects of Radiotherapy Gynae-oncology Clinic – Patient Experience	To evaluate patient's experience of the Gynae Late Effects Clinic.	Consultant	Users views	Data collection stage Analyse current data	N/A	N/A	Active
	Service evaluation of image guided brachytherapy	Image guided brachytherapy has been introduced into Velindre Cancer Centre in the last few years. It is important to monitor outcomes following its introduction	Consultant Medical Student SSC	Key Indicators of Practice	Overall, from all of the data, we can see that the IGBT cohort had much better local control and a reduced proportion of the cohort developing toxicity from the Brachytherapy compared to the standard planning cohort.	Area of good practice	Continue following up patients and re-do yearly/ 2 yearly. Additionally, data from previous years (2014 and before) could be used to increase the data from the standard planning control) cohort.	Complete
3.1	Review of first line bevacizumab in advanced ovarian cancer in South East Wales	To review the number of patients that have received bevacizimab front line for ovarian cancer and to review the outcomes and toxicities	Consultant Pharmacy	Clinical Effectiveness	Data collection stage .	N/A	N/A	Active Proposed completion date March 2023
3.1	Bevacizumab Induced Hypertension in	Bevacizumab can induce HTN, the aim of this project is to look at the incidence of bevacizumab induced HTN,	SpR	NICE Guidance/ VCC Guidelines	Data collection stage	N/A	N/A	Active Proposed completion

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Gynaecological cancers	its management in comparison to NICE guidelines and the follow up.						date June 2023
	PARP inhibitors	Outcome parp appropriateness of treatment and outcome	SpR		Unable to start this audit due to other commitments, thus discontinued.			Discontinued
	Gynae oncology 1st line Niraparib against NICE guidelines'	This audit seeks to evaluate the compliance with current NICE guidelines, of which the set standards are based on, and to ascertain why treatment with Niraparib might be stopped. By evaluating this we can ensure safe prescribing and monitoring of Niraparib with the hope of reducing toxicities and increasing treatment duration, ultimately improving patient	SpR		There were 18 participants in total. The small sample size means that the data is not as significant as it would have been with a larger sample. Further analysis, into whether toxicities become more manageable with a longer treatment duration would be helpful. Increasing age and performance status may result in worse patient outcomes, although due to the small data set this is not reliable. The set standard was met for cancer type, treatment window, monotherapy, FBC monitoring. Better documentation of performance status and blood pressure monitoring is necessary to meet the NICE guidance and standards. The set standard for dosing was not met. Where patients are started on different doses it would be useful to document the reason for this clearly.	Areas of good practice Areas for improvement	Audit findings to be presented at the Gynaecology team at Velindre cancer centre. Discuss whether a current proforma for Niraparib prescribing and monitoring exists, and if not consider creating a proforma	Complete
Head & Neck SST								

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Head and Neck malignancies. There are several aspects to audit our experience and compare to trial data in both Urology and Head and Neck cancer	To evaluate the role of radiomics in predicting outcomes such as progression-free survival and measures of interim tumour response following two weeks of chemoradiotherapy	Consultant Medical Student SSC	SSC	199 radiomics features were analysed. Null features were excluded and two features remained of which neither proved to be a reliable indicator for predicting tumour response to initial chemoradiotherapy. One of the most significant limitations this project suffered from was a very small sample size of only 10 patients. Some weak correlation has been observed, and though my initial analysis has not demonstrated any features that are at present reliable, these features may later prove to be significant.		The PEARL trial is still actively recruiting patients, and, with a more representative dataset, it is possible that more robust features will be identified that can be used to guide not only radiotherapy replanning but even predict progression-free survival.	Complete
3.1	Nivolumab	To look at the local data outcomes related to second line Nivolumab in Head and Neck Cancer from NICE approval of the treatment.	Consultant	Key indicator of practice	Survival analysis was performed from date of referral to date of event i.e. either the date of death or the censored date, which was 15/08/2019. There were 23 patients involved in this piece of analysis, 7 (30.4%) of whom had not yet reached the event of interest (death).	Project showed safe care and appropriate practice	A larger sample size would lead to more reliable results.	Complete
6.3	Nasogastric (NG) tubes patient experience	To look at thoughts and feelings after an NG tube	Consultant	User views	Dietitians & Speech therapists that were doing this audit did not have time or resources to complete it.	N/A	N/A	Discontinued
3.1	30 day mortality post head and neck radiotherapy treatment.	To look more closely at the patients with less than 30 days mortality following treatment. The aim of the audit is to identify if there were indications retrospectively by looking back at bloods results and	Consultant CNS	Key indicator of practice	Data should good practice in line with other centres	Areas of good practice	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		interventions to help us improve future care and early interventions						
3.1	The impact on swallowing outcome of changing radiotherapy technique for the treatment of T1 and T2 glottis cancers.	To assess the impact of changing radiotherapy technique.	SpR	Clinical Effectiveness	Complete awaiting report	N/A	N/A	Complete
	To assess the use of Pembrolizumab in the metastatic /non resectable HNSCC at Velindre Cancer Centre	To assess the use of 1st line Pembrolizumab in metastatic/unresectable recurrent HNSCC population at Velindre Cancer Centre	SpR	NICE Guidance	The introduction of single agent Pembrolizumab took place during the background of the Covid-19 pandemic. Initially, immunotherapy was utilised as a short-term goal to avoid myelosuppression, but as experience with the drug grows, it is increasingly seen and utilised as an option for patients whom are relatively asymptomatic or have non-bulky disease.	Areas for improvement	Results to be fed back to the Head and Neck department and explore the teams experience with the drug to date including reasons for low CPS scoring requests. As a department we can aim to device a system to ensure appropriate testing and utilisation is implemented. The aim would be to re-audit approximately 1 year after implantation	Complete
	Determining the outcome of metastatic carcinoma of cervical lymph nodes from an unknown primary cancer: South East Wales 2007-2016		SpR Consultant		Data Collection	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	A retrospective review of Head and Neck neuroendocrine carcinomas treated in Velindre cancer center over the past 10 years	We aim to look at the management and the outcomes of the neuroendocrine head and neck cancers that were treated in VCC over the past 10 years. These are a rare type of head and neck cancers that were not included in many studies before	Specialty Doctor Consultant	Key Indicators of Practice Clinical Effectiveness VCC Guidelines	Data Collection stage	N/A	N/A	Active Proposed completion date June 2023
	Retrospective review of the recurrent, progressive, or metastatic head and neck cancers (with positive PDL, CPS >1) treated by first line of systemic treatment (Pembrolizumab/ chemotherapy) in VCC over the past 5 years	We aim to look at the management of and compare the outcomes of the recurrent, progressive, or metastatic head and neck cancers(with positivePDL, CPS >1) treated by PEMBROLIZUMAB or chemotherapy as first line of systemic treatment in VCC over the past 5 year**s**. Pembrolizumab was approved by FDA for the use in this entity of patients in 2016. We need to compare our outcome in VCC to the international data	Speciality Doctor Consultant	Key Indicators of Practice Clinical Effectiveness VCC Guidelines	Data Collection stage	N/A	N/A	Active Proposed completion date June 2023
	Total treatment time and time from surgery to RT in Post-Operative Radiotherapy in Head and Neck Cancer	Aiming for Adjuvant treatment (Post-Operative Radiotherapy for SCC of Head and Neck patients to start within 6 weeks in 95%, within 5 weeks in 75% of patients.	SpR		There were 50 Head and Neck patients treated, five out of them were SCC of skin, so they were excluded. Results of our Service, Treatment within 6 weeks, Target: 96%, VCC Compliance 54%. Treatment within 5 weeks, Target 75%, VCC Compliance 20%.	Area for improvement	Lack of staff in Pathology department has been recognised, this audit data can be used to create a business case to hire more Pathologist. Discussion among Oncology consultants if,	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					Review and Compare LRC and mortality between above three groups and see if it has made a difference.		a rota can be made to expedite start of RT. 46 Patients in 1 years = 4 patients in 1 month, i.e. 1 patient / week on Average.	
3.1	Evaluating the accuracy of diagnostic imaging of extranodal extension of metastatic squamous cell carcinoma in cervical lymph nodes	To assess the accuracy and concordance between pre-treatment radiological reports and post-operative pathology reports for the detection of ENE of metastatic cervical lymph nodes in patients with HNSCC.	Medical Student (SSC) Consultant	Clinical Effectiveness	The study showed USS, CT, MRI to have a low sensitivity and accuracy at detecting ENE among HNSCC patients, likely a result of the difficulty of detecting small volume ENE, and highlighted disparity in the concordance between clinical and pathologic N staging in this cohort. Audit highlights our results in detecting ENE are similar to some published studies	Area of good practice	Highlights the need to take into account sensitivity of radiological detection of ENE when making treatment decisions.	Complete
3.1	A service evaluation of the changes in the delivery of non-surgical cancer treatment for head and neck cancer patients in South-East Wales as a result of the COVID-19 pandemic	To look at the changes that were observed in the non-surgical treatment of head and neck cancers during the COVID-19 pandemic. The SSC project is important as it will help identify the impact of the COVID-19 pandemic on the delivery of clinical care which will have implications for the future treatment of patients with head and neck cancers.	Consultant Medical student	Key indicator of practice	The findings of this study demonstrate that the COVID-19 pandemic caused changes in the delivery of non-surgical cancer treatment for head and neck cancer patients at Velindre Cancer Care Centre. The most common change being the use of pembrolizumab as first line therapy.	Areas of good practice	Future work to assess the potential patient outcomes that occurred because of the changes implemented due to COVID-19. Also, the findings could be used to identify which of the changes implemented, should be adapted as standard care for head and neck cancer patients post the COVID-19 pandemic.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Head and neck Oncology team, focusing on surgical management strategies and the involvement of the maxillofacial teams.	To assess surgical management and treatment strategies	Medical student SSC Consultant	Clinical Effectiveness	This retrospective study shows in our population the overall survival and disease free survival was improved in patients with early stage oral cavity cancer who had a neck dissection compared to those who had observation of the neck. Of the patients who required radiotherapy for oral cavity cancer, 17% had documented osteoradionecrosis. Further studies will look at the grade and impact of this adverse outcome in our population. The documented rate of ORN is high, and needs to be considered when deciding on the benefits and risk of adjuvant treatment	Area of good practice	To look in more detail at the grade and impact of ORN, and if significant to develop further strategies to minimise this adverse event.	Complete
3.1	Review of Enteral feeding in Head & Neck patients undergoing radical radiotherapy during COVID 19	Aim is to review which method of enteral feeding; reactive NGT vs prophylactic GT provides the best outcomes for these patients by comparing practice during pre COVID 19.	Consultant	Clinical Effectiveness	With the rest of the Patient Support Unit team, It was a large project and ultimately we didn't have the capacity or staffing to devote the time that was required to complete it.	N/A	N/A	Discontinued
Lung Malignancies SST								
3.1	Audit of outcomes of patients having radical radiotherapy for NSCLC at Velindre Cancer Centre	Compare VCC outcomes to established best practice (as defined by international clinical trials) – overall survival and progression free survival	SpR	Key indicator of practice	Data Analysis Stage	N/A	N/A	December 2023
3.1	Retrospective Data Collection for	To update data to date, looking at outcomes and	Consultant	Key indicator	Data collection stage	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Lung Cancer Radiotherapy FDG PET Relapse Prediction in NSC Lung Cancer	other factors such as genetics and PETS	Medical student	Clinical Effectiveness Innovation				Proposed completion April 2023
3.1	Radical approach in selected patients Stage IV disease	Audit looking at outcomes for patients with limited stage IV disease in whom we've adopted a radical approach, incorporating neurosurgery or adrenal excision, brain SRS or SBRT during their treatment course.	Speciality Doctor Consultant	Key indicator of practice	Project set up stage	N/A	N/A	Active Proposed completion date November 2023
3.1	Real-world experience of carboplatin/etoposide/atezolizumab for SCLC	UK wide retrospective study to review outcomes for a new treatment in SCLC (carboplatin/etoposide/atezolizumab) providing real world experience of how well this treatment works and any side effects that are encountered.	Consultant	Key Indicators of Practice Clinical Effectiveness NICE Guidance	A total of 192 patients were included. Baseline clinical characteristics are summarized in the table. One hundred forty seven (77,8%) patients received four cycles of A-CE; median number of doses of atezolizumab was 7 (range 1-20). Fifty-two (27%) patients also received prophylactic cranial irradiation and sixty-one (31,7%) consolidation thoracic radiotherapy. Seventy-six (39,6%) patients received at least one subsequent treatment. At a median follow-up of 15 months, median progression-free survival (PFS) and overall survival (OS) were 5,31 and 8,85 months, respectively. Overall response rate was 69,7%.	Areas of good practice and areas for improvement	Data from our series show comparable PFS but inferior OS than those reported in the IMpower133 trial. Negative prognostic factors such as performance status ≥2 and presence of brain metastasis at diagnosis were more common in our cohort compared with IMpower133 and may have determined a shorter OS. Real-world data in this setting could help to optimize clinical	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					The OS rates at 12 months and 18 months were 38,25% and 20,36%, respectively. Treatment-related adverse events led to discontinuation of treatment in 32 patients (16,7%). Engagement with a national project which won the Best Poster Award at ESMO Congress 2022. The data has also contributed to this poster submission (see attached) which took place at ESMO immuno-Oncology conference Dec 2022 – international collaboration.  posteresmoIO2022.pptx		management of these patients	
	A retrospective audit comparing toxicity of three weekly versus six weekly pembrolizumab for NSCLC	To compare toxicity of the 2 schedules	Medical Student SSC Consultant	Local Concern	Given the relatively small sample size, limited toxicity events, and inadequate record detail, it is difficult to conclude whether six-weekly pembrolizumab has a similar toxicity profile to three-weekly. Though our findings are non-significant, possibility exists that six-weekly pembrolizumab is more toxic than three-weekly	N/A	Limitations mean further research is needed to draw firm conclusions. Repeating the audit on a larger scale is crucial. It would be important to further consider baseline characteristics as predictors of toxicity severity within this.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Use of single agent check-point inhibitor pembrolizumab in metastatic non-small cell lung cancer	To assess toxicities encountered by patients receiving this treatment including immune related adverse events. To assess outcomes of patients receiving pembrolizumab.	SpR	VCC Guidelines Clinical Risk Local Concern	Was delayed due to COVID and maternity leave. this will be discontinued as data collected previously is now outdated	N/A	N/A	Discontinued
3.1	All Wales NSCLC genetics pathway quality improvement project	To assess current turnaround times for genetic results for NSCLC, identify gaps and improvements to reduce pathway variability and improve equity of access/turnaround times	Consultant	National guidelines, Local concern, Clinical effectiveness	**Data was submitted from 7 MDTs for 53 patients with NGS testing between October 2020 and May 2021. 40 (75.5%) patients had both DNA and RNA NGS, the remainder had DNA NGS +/- FISH testing for ALK/ROS/NTRK gene rearrangements. Median TAT from biopsy to results for DNA and RNA NGS was 26 days and 25 days, respectively (figure 1); MDTs with reflex testing had shorter TAT. DNA NGS testing was successful in 51 (96.2%) patients; RNA NGS testing was unsuccessful in 10 (25%) patients however salvage FISH testing gave results in 7 cases. Testing identified clinically actionable variants in 17 (32%) patients.**	Areas for improvement  BTOG abstract_final.docx	**In order to improve time to definitive treatment and patient outcomes, the diagnostic pathway TAT need to be reduced. The Welsh Thoracic Oncology Group plans to review the NOP to optimise and standardise genomic testing. Specifically the AWMGS has established a working group to facilitate implementation of a 7 day target for NGS results from time of sample receipt; priorities include increasing the number of NGS runs per week, increasing staff capacity for sample processing, result reporting and authorisation, and optimising DNA/RNA**	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
							extraction methods to reduce testing failure rates.	
	Atezolizumab	In July 2020 NICE approved atezolizumab in patients with advanced SCLC based on the IMpower133 study, creating a new standard of care (SoC) for patients of good performance status (PS) and advanced SCLC	SpR Consultant		Despite early adoption, <20% patients with SCLC accessed atezolizumab. Overall, atezolizumab was well tolerated. Range of fitness at baseline varied (25% PS 2 or worse). Use of CTRT/PCI was low. 32% had palliative thoracic RT for thoracic relapse. Survival and duration of treatment compared favourably with trial data	Areas of good practice	N/A	Complete
Urology SST								

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Comparison of Time to Treatment Failure and Consistency of Response Duration of Sunitinib, Cabozantinib and Combination Immunotherapy with Ipilimumab and Nivolumab as First-Line Treatment .	We currently use immunotherapy to treat renal cancer. This study aims to determine the time elapsed until treatment failure for both tyrosine kinase inhibitors and combination immunotherapy with ipilimumab and nivolumab as first-line treatments.	Consultant Medical Student SSC	Key indicator of practice	Sunitinib provides a more reliable and longer time to treatment failure than combination immunotherapy with ipilimumab and nivolumab as first-line treatment. Cabozantinib was not able to be reliably studied due to the small sample size.	Are of good practice	Future research can be conducted focussing on the long-term outcomes of patients on ipilimumab and nivolumab for renal cell carcinomas; and also to gain further understanding of these agents themselves, hopefully providing explanations for some of the findings. There may also be scope for conducting this study but with a larger sample population so that the results obtained are more accurate and reliable, and less subject to extremes of data. The treatment response to individual doses of each drug can also be studied	Complete
3.1	Prospective data collection HDR PROMS and outcome (first 18 months)	To collect patients related outcome measures	Consultant	PROMS	Data Collection Stage	N/A	N/A	Ongoing
3.1	SABR / SPACER programme data (first 18 months)	To collect patients related outcome measures	Consultant	PROMS	Data Collection Stage	N/A	N/A	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Outcome of ADT and docetaxel for hormone-sensitive metastatic prostate cancer	To evaluate the outcomes of metastatic patients cancer patients who have received ADT and docetaxel.	Consultant	Key indicator of practice SSC	No longer required due to change in practice	N/A	N/A	Discontinued
3.1	Investigating lines of therapy and survival outcomes in Renal cancer	To ascertain overall survival and grade of toxicities	Medical Student SSC Consultant	Key indicator of practice	As new treatments continue to be offered for mRCC its important the best treatments are offered at first and second line to improve survival outcomes for these patients	Areas of good practice Ares for future work	A larger study would allow better statistical analysis of survival times and comparison of specific treatment types.	Complete
	Multi centre audit of treatment and survival outcomes in Renal cancer	To ascertain overall survival and grade of toxicities	Consultant CAD	Key indicator of practice	These results suggest that with more treatment options available, including combination/immunotherapy therapies, more patients are able to receive second- and third-line therapies. Nearly one third of patients only receive one line of treatment which highlights the need to deliver the most efficacious treatments first to optimise patient outcomes.	Areas of good practice Areas for future work	1.Increase number of UK centers involved in real world study. 2.Consideration how licensing of new combinations influences survival in each treatment line 3.Differential responses and outcomes depending on sites of metastatic disease. 4. Will be presented in San Francisco.	Complete
	Standard Radiotherapy prostate 60gy/20# PROMS and outcome		Consultant radiographer		Data Collection	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Treatment Patterns and Survival Outcomes in Patients With Metastatic Renal Cancer at Velindre Hospital	To identify the relationship between overall survival and increased number of lines of therapy in metastatic renal cancer patients receiving systemic treatment	Medical Student SSC Consultant	Key indicator of practice	More patients with metastatic renal cell carcinoma need to be offered more than 1 line of therapy. The current criteria used to dictate which treatment individual patients receive needs to be updated	Areas for improvement Areas for future work	More research needs to be conducted to better identify patients suitable of progressing to more than 1LOT. Furthermore, the IMDC risk criteria currently used to dictate which therapy patients receive is outdated, further research is needed to find alternative means of estimating prognosis of mRCC	Complete
	Ipi NiVo - A single centre real-world observational study of ipilimumab + nivolumab (I + N) in advanced intermediate and poor risk renal cell carcinoma (aRCC): 24-month interim results.	This study reports real-world outcomes in patients with aRCC receiving I + N at a tertiary cancer centre.	Consultant SpR		This analysis included patients with a minimum follow-up of 16 months. Median age at baseline was 64 years (range 45-80); 71% (n=34) of patients were male, IMDC risk status was, intermediate in 77% (n=37), and poor in 23% (n=11). Clear cell was the most common histological subtype (63% [n=30]). 31% (n=15) in patients who had undergone nephrectomy. The OS rate at 12 months was 65% with a median OS of 17.2 months. The overall PFS rate at 24 months was 23%, with a 12 month PFS rate of 33% and median PFS of 6.6 months. ORR was 65% (31) with 8% (4) having a complete response and 57% a partial response (n=27).	Area of good practice	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Bone health evaluation at Velindre Cancer Centre in September and October 2021		Lauren James Dr Andrew Kidd		All new adjuvant and metastatic patient referrals to VCC in September and October 2021 were reviewed. Our service evaluation findings demonstrate that most patients with locally advanced and metastatic prostate cancers who attended VCC in September and October 2021 did not have bone health assessment using FRAX®.	Patients with locally advanced and Metastatic prostate cancers receiving long term hormones need a bone health assessment carried out using FRAX	The results of this service evaluation will be summarised in poster format and disseminated to all relevant parties. A teaching intervention will be arranged and a further service evaluation cycle.	Complete
3.1	A retrospective evaluation of brachytherapy treating patients with prostate cancer	To look at patient disease outcome measures assessed during cancer therapy	Medical Student SSC Consultant	SSC	The findings of this project show LDR brachytherapy to have an effective disease-specific survival rate, an effective biochemical relapse-free survival rate and to be more successful in terms of biochemical relapse-free survival for low-risk patients compared to intermediate-risk patients.	Area of good practice	N/A	Complete
3.1	Changes in the delivery of treatment for patients with urological cancer during the COVID-19 initial 'peak	To monitor changes to treatment pathways and associated outcomes	Medical Student SSC Consultant	Key indicator Clinical Effectiveness	Many urological cancer patients had their systemic treatment changed directly due to the COVID-19 pandemic. Changes made were mostly to limit the patient's time spent in clinical environments. These changes were in-line with various different guidelines.	Areas of good practice	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Newly diagnosed hormone-sensitive metastatic prostate cancer and the impact of androgen-receptor targeted agents during the COVID 19 pandemic	To evaluate the presence and impact of toxicity of these new drugs on patients during the COVID period and how we have had to adjust drug dosages/ management plans accordingly.	Medical Student SSC Consultant	Key indicator of practice Clinical effectiveness SSC	Overall, all three drugs have shown good early response in reducing the PSA and preventing disease progression in real life group of patients. The side effects identified in this analysis is consistent with the clinical trials but, a greater percentage of patients experienced each side effect compared to the clinical trials	Areas of good practice Areas for further work	Treatment duration and sample size was also limited therefore further follow up analysis needs to be conducted to understand if response to these drugs is maintained by calculating overall survival	Complete
3.1	Stereotactic Ablative Radiotherapy (SABR) Metastatic prostate	To evaluate the outcomes of prostate cancer patients who have received SABR, in terms of time to biochemical progression/ time to initiation of ADT/SACT	Medical Student SSC Consultant	Key indicator of practice SSC	SABR is a promising management approach for oligometastatic PCa patients who wish to prolong their time to starting ADT showed excellent practice which is always reassuring especially as it is a relatively new technique. No areas identified as needing improving.	Are of good practice	Further investigation in this area is required	Complete
Palliative Care SST								
3.1	A review of advance care planning practices locally and in Wales	Review local and national policies incl www.wales.nhs.uk/afcp and write a paper for British medical journal supportive and palliative care	GP ST1 trainee in palliative care Consultant	National guidance QI Project	Advance and future care planning is an approach with many different facets. In Wales, we have found that some patients prefer a clearly set out, legally binding 'Advance Decision to Refuse Treatment' to guide their care, while others prefer a softer, guiding approach captured through an Advance Statement. All these formats are available to patients, carers and healthcare professionals, together with explanatory guidance notes, through a central Welsh website. Patients in Wales now have access to information resources and forms	Areas of good practice Area for improvement	Next steps involve getting a central electronic repository for these forms, which is accessible to healthcare providers and to patients.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					that can suit different needs. Patients who wish to fill in their own documents can do so via a centrally hosted site, which has guidance notes and documents. The approach in Wales offers several policies, information resources and forms, all catering for different needs.			

3.1 3.5	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit	To ensure the patient's rights and wishes are respected. To ensure that a DNACPR decision is clearly recorded and communicated between health professionals and patients. To ensure that the All Wales DNACPR policy's recommendations are adhered to. To make use of audit proforma as recommended by national policy.	Consultant SpR	National guidance	This audit showed good completion and recording on All Wales DNACPR forms, and that patients were part of a consultation. The introduction of the new version of the national form, plus a Grand Round education session for all clinical staff, with further small group tutorials and events, served as a mid-audit intervention. Second data collection showed free-text communication and documentation on forms, incl what had been discussed with patients and significant others, as well as documenting reasons on rarer occasions when conversations could not take place. For instance when a patient made it clear that they did not want to discuss matters surrounding end of life care, or when it was felt that bringing up with topic would cause significant harm. The forms should merely be a reflection of excellent communication about a topic that can be emotional for some, but it showed good adherence to the 'duty to consult'. Evidence of full and clear communication about what CPR is, how low success rates can be in certain individual situations, and that a DNACPR form does not mean that all other forms of care aren't available, was present in written communications. was often found in the medical notes	Area of good practice	Next steps are ensuring these forms remain with patients when they change care setting, and are clearly communicated to all individuals involved in their care across acute and community settings. This is likely to be achieved most effectively and safely via a central electronic repository for advance and future care plans, which is accessible by all relevant healthcare providers and NHS Wales IT systems, as well as patients and their carers. Re-audit 2 years	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1 3.2	Symptom Control QI Project including POS-S	Evaluation of the use the POS-S within palliative care team	Consultant Medical Student SSC	Clinical effectiveness	9 out of 10 of the symptoms were improved during an inpatient stay at VCC. Poor appetite was the most improved symptom between day 0 and day 7 (percentage difference of -65.2%). Drowsiness was the only symptom that had an average increase in severity over the time-period (percentage difference of +56.8%). The palliative care team at Velindre are successful at managing common palliative symptoms. This is achieved through careful assessment and a patient-centred, multidisciplinary approach to management	N/A	This study would Benefit from annual evaluation. Also, an update to POS-S has been developed to look a bit more at psychological symptoms. This is the newer i-POS tool , and it is likely this will be integrated into the Velindre IT Canisc replacement system for palliative care over the coming year.	Complete
3.1	A review of dry mouth and its management	A QI project with Velindre library to produce a guideline paper, possibly for publication in a palliative care journal and/or European Association for Palliative Care	SpR	National guidelines, literature review	Audit has been discontinued as too busy with pandemic and related clinical pressures.	N/A	N/A	Discontinued

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Naloxone use in Velindre- a survey	The BNF has recently changed its recommendation on the dose of Naloxone in Palliative care settings. We review current views on dosing amongst Velindre doctors and there will be a consensus review of the current Pain Guidelines and Naloxone guidance	Consultant SpR	BNF, National Guidelines, local policy (incl Pain policy)	Reg Datix of Naloxone events closely monitored	Area of good practice	Naloxone dose for pall pat changed in guidelines	Complete
3.1	Cancer Associated Thrombosis (CAT) MDT	This audit seeks to better understand the CAT MDT patient population and know how and where the CAT guidelines are applied.	Consultant	NICE Guidelines	Data collection The work is on-going although, hope to present at international conference	N/A	N/A	Active
	Is primary thromboprophylaxis of palliative care cancer in-patients compliant with NICE Clinical Guideline 89 A clinical audit	To audit the risk assessment and where appropriate, the initiation of thromboprophylaxis in inpatients with cancer who are under the care of the palliative care service.	Doctor	National Audit	1. Data analysis ongoing 2.The SPCU and acute hospital palliative care patient differ •Reason for admission •Disease trajectory •Performance status •Anti cancer therapies 3.They are similar for •Indications for anticoagulants and antiplatelets •Proportion taking anticoagulants and antiplatlets All palliative inpatients had a documented risk assessment and practice was in keeping with NICE VTE prophylaxis recommendations.		Await full data analysis from national audit to guide future recommendations.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Review of treating Cancer Associated Thrombosis (CAT) in patients with primary brain tumours	To review the clinical management plans for patients referred to the CAT clinic with diagnosis of superficial vein thrombosis and review whether we are adhering to NICE guidelines.	Consultant	NICE Guidelines	Discontinued no SSC attended to undertake and no other resource to take forward	N/A	N/A	Discontinue
Colorectal SST								
3.1	Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer	Compare the clinical effectiveness of short course Radiotherapy with long course radiotherapy. to see if there was an additional benefit of a combination of giving chemotherapy before and after short course radiotherapy	Consultant SpR Medical Student SSC	Key indicator of practice Clinical Effectiveness	Data collection stage	N/A	N/A	
3.1	Improving communication standards of clinic letters within the colorectal service in Velindre	A focussed audit of communication standards for patients within the colorectal team to establish what we already know, that in all likelihood the situation has not changed since 2018. Trial the communication framework using a 'rapid cycling' method to improve the relevance and the efficiency of information input	GP SpR	Royal College	Compared to the last audit in 2018 time taken to type clinic letters performed better in this site team from a mean 25 days to mean of 3 days. Overall there has been good improvement in the structure and documentation of essential information in clinic letters, and staff have found the new format easy to adapt to with the guidance notes provided	Areas of improvement identified	Key workers should be added to the guidance notes. Project objectives and guidance notes for dictation to be cascaded to SHOs and SpR's. Take the project to other teams within GI cancer, disseminate audit findings and implement the new template	Active Proposed completion date April 2023
3.1	Rectal Simultaneous Integrated Boost (SIB)	TBC	SpR Consultant	TBC	Project set up – Lead on Mat leave will undertake on return on hold	N/A	N/A	Proposed completion date December
3.1	Rectal contact Radiotherapy	To Evaluate the selection criteria, and outcomes for patients who are treated with	SpR Consultant	NICE	Data Analysis stage	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		contact radiotherapy for rectal cancer						Proposed completion date July 2023
	A Service Evaluation of the Management of Immunotherapy Toxicity in Colorectal Cancer Patients in SE Wales	Assessing all patients with metastatic colorectal cancer treated with immunotherapy in Velindre Cancer Centre and identifying the diagnostic pathway for treatment toxicity and the management of these patients, including the use of high dose steroids.	Consultant Medical Student SSC	Clinical, Service Evaluation	Grade 1 irAEs were generally managed conservatively, in line with the current VCC guidelines. However, grade 2 irAEs were more varied in management and required judgement of the clinical situation. Guidelines were followed in the majority of cases with steroids and a temporary stop in immunotherapy implemented and permanent cessation of immunotherapy in the case of non-resolving symptoms. The grade of toxicity was generally poorly recorded with only 35% of irAEs reporting the grade at the time of diagnosis. The clinical reasoning behind management plans that differed from the guidelines was also not well documented.	N/A	Improvements could be made in documenting grading the irAEs and clinical reasoning where management differs to guidelines.	Complete
	The introduction of aspects of the Royal College of Radiologists (RCR) IMRT guidance for national rectal cancer for long course chemo radiotherapy patients	The pilot will enable us to assess introduction of the recommended changes on all staffing groups and support the permanent implementation of certain aspects of the IMRT guidance	Consultant	Service development	Data collection stage	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
UGI SST								
	THE DIFFERENCE IN TREATMENT OUTCOMES IN PATIENTS RECEIVING HIGH DOSE PALLIATIVE RADIOTHERAPY VS LOW DOSE RADIOTHERAPY IN ADVANCE OESOPHAGEAL CANCERS	To determine the palliative intent for patients receiving either high dose (HD) or low dose (LD) radiotherapy and determining whether there is a significant difference in the length of survival time, and patterns of disease progression. In addition, the study will assess the adverse toxicities that patients may be predisposed to on treatment.	Consultant Medical Student SSC	SSC	High dose palliative radiotherapy regimens were associated with greater overall survival outcome and progression free disease in comparison to low dose palliative radiotherapy regimes. However, there is a higher risk of radiation related acute toxicities and need for re-intervention, which need to be considered prior to initiating treatment. However, low dose radiotherapy has a role in the management of progressive symptoms, especially for oesophageal bleeds and rapid progression		Further research can be conducted to appreciate the impact of LD radiotherapy, for instance the change in requirement of blood transfusion pre- and post-radiotherapy intervention to manage bleeding and anaemia. Overall, a multi-disciplinary approach should be taken to conclude suitability of the treatment regimens, looking at the performance status of the patient, burden of disease, ability to tolerate radiation and severity of symptoms.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Treatment for advanced pancreatic cancer	To collect and evaluate clinical data of patients with advanced pancreatic cancer at Velindre Cancer Centre. To evaluate the outcomes of oncological therapy including chemotherapy and radiotherapy.	Consultant Medical Student SSC	Clinical effectiveness SSC	The results showed an improved overall survival and progression free survival in patients receiving FOLFIRINOX therapy. Improved overall survival (OS) of 3.7 months and increased progression free survival (PFS) of 5.7 months when compared to gemcitabine plus nab-paclitaxel. An improved PFS and OS with FOLFIRINOX was also noted in a previous study by Conroy et al. 2011.	N/A	N/A	Complete
3.1	TREATMENT OF OESOPHAGO-GASTRIC CANCER IN VELINDRE	To explore chemo-radiotherapy outcomes for oesophago-gastric cancers in Velindre and compare outcomes in South East Wales with other areas. The secondary aim is to look at data to explore factors contributing to poor outcomes.	Consultant Medical Student SSC	Clinical effectiveness Patient safety SSC	There is a degree of anatomical overlap between upper third and hypopharyngeal tumours, despite this overlap, they are treated very differently and the outcomes differ. • Survival – the upper third tumours, had a 32.2% higher probability of survival at 1 year. The hypopharyngeal cohort presented with a more advanced T stage, greater levels of lymph node involvement and more comorbidities. • Both groups had a similar recurrence rate; 38% hypopharyngeal compared to 29% for the upper oesophageal tumours. Other studies have identified recurrence rates of 57.1% in post cricoid and upper third tumours.	None	86% of recurrences occurred locally in the hypopharyngeal group. This suggests that current treatment for tumour of the hypopharynx poorly controls local disease, despite the aggressive treatment. • The recurrence of the upper third tumours, were distant metastases, which suggests that there are poor options for systemic treatment.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	CLINICAL OUTCOMES OF LOCALISED PANCREATIC CANCER POST-ONCOLOGICAL THERAPY	To collect and evaluate clinical data of patients with localised pancreatic cancer at Velindre Cancer Centre. To evaluate the outcomes of oncological therapy including chemotherapy and radiotherapy.	Consultant Medical Student SSC	Clinical effectiveness SSC	Median OS for the whole cohort was 9.3 months. Out of 103 patients with LAPC/BRPC, only 5 (4.8%) underwent surgical resection following downstaging with oncological therapy. Surgical resection conferred the greatest survival benefit with a median OS 22.8 months. This was followed by combination chemotherapy and CRT (median OS 13.8 months) and chemotherapy alone (median OS 7 months). There was no significant variation between chemotherapy regimes.		Larger scale, randomised control trials are required to provide stronger evidence in order to optimise outcomes in these patients.	Complete
	WHAT IS THE LOCAL PRACTICE OF IDENTIFYING AND MANAGING IMMUNOTHERAPY-RELATED TOXICITY COMPARED TO THE ACCEPTED GUIDELINES?	This Audit will review local practice of managing immunotherapy toxicity in GI and hepatopancreaticobiliary cancers in Velindre Cancer centre, in comparison to the Guidelines.	Consultant Medical Student SSC	VCC Guidelines	66.67% of patients had both pre-treatment bloods carried out and were given pre-treatment medications. 68.57% of toxicities were graded which does not meet the target of 100%. 74.29% of toxicities were managed according to the guidelines and therefore, met standard 3. The highest performing standard was standard 4, with 77.14% of patients having been followed up	Areas of improvement are to increase the grading of identified toxicities and to check that all patients have received pre-treatment medications.	All standards have been met in the majority of cases	Complete
3.1	Management of Oesophageal Squamous Cell Carcinoma within the UK and Ireland: A retrospective multi-centre analysis	Provide an insight into variation across the UK in the use of surgery and dCRT for the potentially curative treatment of OSCC. Review survival outcomes for CRT compared with neoadjuvant treatments plus surgery.	Consultant	National Project (NOTCH)	Data submitted Awaiting national report			Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	DM, BMI, Chemo Regime , PS and comorbidities Influencing Clinical Outcome in patients with Metastatic Pancreatic Cancers	To evaluate & compare factors influencing Clinical Outcome in Pancreatic Cancer	SpR Consultant	Key Indicators of Practice/Clinical Effectiveness/Royal College	Audit discontinued as lead rotated to Swansea.	N/A	N/A	Discontinued
	An Audit of emergency presentations and referrals of patients with oesophagogastric cancer	To look at emergency presentations and referrals of oesophago-gastric cancer from Welsh health boards that were submitted to the National Oesophago-Gastric Cancer Audit (NOGCA) 2020, and verify whether they were true emergency presentations.	Medical Student SSC Consultant		The results suggest that the reason for why the emergency referral rate from Wales is high is not due to the way in which emergency referrals are recorded.	Areas for improvement	Work needs to be done to look into the reasons why the rate is higher in Wales than in other regions of the UK	Complete
	A Clinical Audit into the Outcomes of Radical and Palliative Patients Treated with Chemo-radio Therapy for Oesophageal Cancer	To identify the average overall survival and progression free survival of the patients presenting in South Wales with oesophageal adenocarcinoma that receive neoadjuvant treatment and radical surgery	Medical Student SSC Consultant	Key indicator of practice	This study finds that the use of neoadjuvant chemoradiotherapy in patients with oesophageal adenocarcinoma has a higher survival outcome. This study can be used to contribute to other large scale national trials that have published similar findings	Areas of good practice Areas for future work	Similar research could be carried out on a larger scale and confirm the stage of the tumour at diagnosis to consolidate these findings.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Evaluation of outcomes from Palliative patients treated with chemo-radiotherapy for oesophageal cancer	To ascertain overall and progression free survival. To identify any toxicities of treatment	Medical Student SSC	Key indicator of practice	The overall 5-year survival of patients treated for OSCCs at Velindre was 31.4%. Patients who received neoadjuvant treatment followed by surgery had the highest overall 5-year survival (53.8%). Early detection of the disease is imperative to increase overall survival. Neoadjuvant treatment followed by surgery had the highest individual overall 5 year-survival but must be interpreted with caution due to the limited sample size.	Areas of good practice Areas for improvement	Early diagnosis of the disease is crucial for improving overall survival, a regular screening programme has yet to be implemented. Multi-modal combination therapy has been mentioned as a future treatment option which would combine surgery, chemotherapy, radiotherapy, targeted therapy and immunotherapy.	Complete
3.1	An audit of variation in delays in the current diagnostic pathways in patients presenting with oesophageal cancer	We will look into 3 Health Boards across South-East Wales, and audit the waiting times and delays in oesophageal cancer referral treatment. We will compare this to the National Optimum Pathway, and we will then look into how this affects the prognosis of the patients.	Medical Student SSC Consultant	Key indicator of practice	The average waiting times across the cancer pathway in the 4 health boards were considerably higher than the target times stated in the National Optimum Pathway, and showed similar results to the National Audit. This project has revealed how different health boards in South Wales compare in waiting times during the cancer pathway, and emphasises the need to keep organisation throughout health boards.			Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Identifying toxicities experienced during immunotherapy treatment for upper GI cancer and biomarkers measured before and during treatment	Autoimmune-like toxicities, known as immune-related adverse events (irAEs) occur in up to 50% of patients. These toxicities can be from skin lesion such as dermatitis to more life-threatening endocrinopathies. Blood tests before starting treatment and before each cycle are vital to reduce the incidences of irAEs. Our audit aims to identify whether these investigations were carried out.	Consultant Medical Student SSC	SSC	Our results showed that GI toxicities were the most common at 71%. High grade toxicities e.g grade 4 were found in kidneys (ie nephritis). The most common toxicities were nausea, fatigue and diarrhoea. Our results show that the required blood test pre-treatment and pre-cycle stipulated in the immunotherapy toxicity guidelines were not followed. Pre-cycle TFTs and cortisol levels were not measured at a target of 100% of the time. It is important that these tests are implemented into normal practice to reduce the risk of life-threatening toxicities.	Generally the Upper GI team have adopted the introduction of IO therapy rapidly. All consultants commented on the new burden of care in terms of new demand with regard to systemic therapies. Broadly the team are managing these patients very well and all of the team were keen to know how they could improve the care of these patients.	Our audit shows that nausea and vomiting are common toxicities experienced in patients on immunotherapies. Healthworkers should make patients aware of these symptoms. In addition, all biomarkers in the pre-treatment and pre-cycle blood test were not taken. Ensuring these are taken is vital in order to prevent life-threatening toxicities.	Complete
3.1	Clinical and histological response of oesophageal adenocarcinomas to neoadjuvant chemotherapy versus chemoradiotherapy: a baseline centre-based audit	The mainstay of treatment for oesophageal adenocarcinoma (OAC) is surgical resection, usually following neoadjuvant chemoradiotherapy (NACRT) or chemotherapy (NACT). This study aims to audit the clinical and histological response to these regimens in OAC patients from one specialist centre.	Medical Student SSC Consultant	SSC	The results of this audit indicate that NACRT may offer superior radiological and histological outcomes for OAC, compared to NACT. Reported rates of pCR and clinical CR are similar to those observed in large multicentre trials, suggesting that local neoadjuvant management of patients with OAC reflects current best practice.	Areas of good practice Areas for future work	Future work should aim to ascertain the clinical significance of these radiological and histological endpoints by correlation with patient outcomes	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	An audit of Patients undergoing radical and palliative treatment for squamous cell carcinoma of the Oesophagus at VCC	To evaluate survival in patients diagnosed with potentially curable squamous cell carcinoma of the oesophagus (OSCC) treated at Velindre Cancer Centre according to age at diagnosis, cancer stage and grade, and initial treatment received	Medical Student SSC Consultant		Overall survival outcomes are evidently very poor in patients diagnosed with OSCC despite treatment, with an average life expectancy of 3 years after initial diagnosis. However, some treatment is better than no treatment and dCRT is the most popular treatment modality	Areas of good practice Areas for improvement Areas of future work	One key point identified in this audit is the need for clear documentation of results, investigations and treatment in patient notes. We were unfortunately unable to analyse progression-free survival in this audit and more studies need to be carried out with regards to survival outcomes in oesophageal cancer patients	Complete
Neuro-oncology SST								
3.1	Management approaches in Grade III (Malignant) Meningioma: a NOTCH UK multi-centre case series	To gain insight into the radiotherapy approaches currently being used across the UK, both in an adjuvant and disease recurrence setting. Data on systemic management and associated disease response will also be valuable for treating clinicians given the lack of evidence base in this area.	SpR	National Project	Awaiting national report	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Interval GB-Imaging timing after surgery for glioblastoma - an evaluation of practice in Great Britain	A UK and Ireland multi-centre retrospective study of imaging practice after surgery for glioblastoma to identify adherence to NICE guidelines, and evaluate imaging strategies utilised. Primary objective to assess MRI surveillance practice after surgery for patients with glioblastoma, and delineate if adherence to NICE guidelines improves survival.	Consultant	National Project NICE guidelines	SW to contact RS	N/A	N/A	Active Proposed completion date August 2022
3.1	Reviewing and developing local guidelines for glycaemic control and bone protection in patients with brain tumours taking glucocorticoids.	To assess current practice and create local guidelines for the use of glucocorticoids, such as dexamethasone in the neuro oncology outpatient department (OPD) at Velindre Cancer Centre (VCC).	Consultant Medical Student SSC	SSC Project	Clinical notes and data from 99 patients was collected and analysed from the neuro oncology OPD clinics from June 2021 to February 2022. 10 patients developed steroid induced diabetes and 9 patients developed steroid induced osteoporosis. It was found that the current use of dexamethasone in the neuro oncology OPD at VCC is not in line with what the created guidelines suggest as best practice	Areas for improvement	The new guidelines should be trialled, and the audit tool should be used to conduct a future audit to assess whether the guidelines are being used correctly and if they are working to minimise steroid induced osteoporosis and diabetes. Maybe re-audit in early 2023 once the guidance has been introduced.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid Wales	Second-line surgery is a considerable undertaking for patients with limited life expectancies and a consideration for surgical resources. To date, our local practice has not been reviewed and doing so will allow us to better define the patient population most likely to benefit and inform our discussions with patients.	Consultant Medical Student SSC	Clinical effectiveness SSC Project	Data collection	N/A	N/A	May 2023
3.1	Audit of SRS	To review outcomes of patients receiving SRS within Velindre	SpR Consultant	Key indicator of practice	266 SRS treatments were delivered to 225 patients. [NSI(-C1] 224(84%) were first treatments and 37(14%) were second treatments. 51(23%) patients also had whole brain radiotherapy. Median age was 64(range 23-85), 124(55%) patients were male and 101(45%) female. The most common primary sites were lung (42%), melanoma (18%) and breast (16%). Most patients had PS 0 (26%) or 1 (41%). 48(21%) patients did not have PS documented. Abstract submitted to - BNOS conference	Areas of good practice identified	SRS and SRT are well tolerated and effective treatment options to improve intracranial disease control for patients with brain metastases.	Complete
Sarcoma SST								
5.1	Sarcoma Pathway	To assess the pathway.	CNS	Key indicator of practice	Data collection stage.	N/A	N/A	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
Other Sites/Services								
3.1	Investigation & Management of iron deficiency anaemia in patients with gastrointestinal malignancy:	Use of blood transfusion, intravenous iron and oral iron	Ashley Poon-King	Key indicator of practice	Paused implementation of iron infusion policy due to COVID restrictions and pressures on day unit etc. data was never finished, would now be too old and not relevant so close audit down.	N/A	N/A	Discontinued
3.1	All Wales Acute Oncology Project – a trainee led service evaluation of acute oncology activity across Wales during the pandemic	Aim to identify key clinical lessons from this period to guide local QI projects and help awareness to improve patient care currently and in case of further surge in covid19 cases.	Consultant	Key indicator of practice Local concern Patient safety	Data collection stage	N/A	N/A	Active
5.1 3.1	Treatment Escalation Plan Quality Improvement Project Proposal	To ensure that more patients will have appropriate escalation plans put in place EARLY in their admission.	SpR	Multi centred	Awaiting report	N/A	N/A	Complete
3.1	Implementation of the 'Antibiotic Review Kit (ARK) Project' into VCC	To provide assurances around antimicrobial stewardship. These measures aim to provide re-assurances that prescribing practices are in line with best practice.	SpR	Key indicator of practice VCC Guidelines 1000 Lives	Data collection stage	N/A	N/A	Active Proposed completion date June 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Immuno toxicities Clinic – Patient Experience of virtual clinic during the COVID-19 Pandemic	Understanding of patient experience of a virtual (telephone) toxicity clinic during COVID-19 pandemic, to assist with future development and learning of a virtual service.	Inpatients	Users/ Patient views	On hold lead is leaving VCC may not have the resource to undertake	N/A	N/A	On hold
	DPYD Health Technology Assessment Service Evaluation	To conduct a health technology assessment (cost utility analysis) of the *DPYD* genotyping service in Wales.	Richard Adams Angharad Rudkin	National	Awaiting Report	N/A	N/A	Complete
	An External Validation Study of the Oswestry Spinal Risk Index (OSRI)	To carry out a third and more up to date external validation of the OSRI	Medical Student SSC Consultant		From our experience, the OSRI is an easy-to-use prognostication system, with only two components (PTP and GC), compared to previous scoring systems which have had three or more. Despite its simplicity, our study shows it to be transferable to patients outside the original data population; we therefore conclude it to be a valid scoring system and recommend its use.	N/A	Recommend the use of the OSRI	Complete
	Immune checkpoint inhibitor induced liver injury: a multi-centre experience	We aim to determine epidemiology of immune checkpoint inhibitor induced liver injury (CPILI), immune-related adverse events (IRAE) and to study management options and outcomes across different UK centres	SpR Consultant	Multi centred project	Data collection	N/A	N/A	Active Proposed completion 26 May 2023

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	How effectively are we diagnosing major endocrinopathies secondary to immune check point inhibitor therapy?	To establish whether diagnosis, investigation and initiation of secondary endocrinopathies is timely.	Consultant Student	Patient Safety	Difficulties with project set up due to gaining access	N/A	N/A	Active
	Cancer of Unknown Primary (CUP) Patient Experience Questionnaire	Evaluate patient experience – this is a new service, and service development should be focused around the patient experience from the onset	Consultant CNS	Users/Patient views	Project setup	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	A Service Evaluation of the Diagnosis of Myeloma in the Emergency Setting	This SSC is an evaluation of the myeloma service in the Cardiff & Vale Health Board, with a focus on the incidence and outcomes of those patients diagnosed via emergency presentations.	Consultant Medical Student SSC	SSC	This SSC identified an association between emergency presentations of myeloma and worse outcomes for patients – with advanced disease staging at diagnosis and reduced 1-year survival for patients. With 37% of patients in the Cardiff & Vale Health Board presenting via emergency routes, it is therefore important to address ways to reduce this method of presentation. However, in many cases, emergency presentations are not only unavoidable but also a key part of the myeloma service, and this SSC did not identify their occurrence as being necessarily explained by a delay in diagnosis in comparison to non-emergency presentations.	Further work could include other diagnostic pathways, such as assessing referral urgency, GP referrals to other secondary specialities, and which emergency presentations attended directly via their GP. In addition, other service intervals could be assessed, such as time from presentation to diagnosis, and time to start of treatment to assess for any delays affecting service efficacy. Additionally, survival analysis could be extended to study a 5-year time period to assess for any longer-term differences.	Given the often-non-specific nature of myeloma presentations, there is still scope to reduce the number of prior presentations that occur before diagnosis, in order to aid earlier diagnosis and prevent emergency presentations and their associated worse outcomes.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Compliance with completion of Treatment escalation plan forms (TEP) for the new admissions to the First-floor wards of Velindre Cancer Centre	The aim of this audit is to check our compliance with completing TEP forms and to encourage the teams to made escalation decision at the point of post take ward round.	SpR Consultant	Patient Safety	Data collection	N/A	N/A	Active Proposed completion date May 2023
COVID-19 Audit/Project Programme								
6.3	Virtual consultation-study in Covid-19 era: Patient and Staff experience retrospective review	To obtain patient and staff vires with regards to their experience with virtual clinics	Sonali Dasgupta Kate Hammond Sarah Seary/Attend Anywhere team	Users Views	Tight study frame to capture clinical parameters from clinics (mainly VA) over first peak of COVID-19 pandemic and compare to retrospective data from clinics (mainly F2F) pre COVID- pilot study. During COVID -19, in keeping with national trend/recommendations(1)Majority were VA(2)Overall treatment numbers were lower; majority were palliative intent(3)Proportion of oral chemo and SA immunotherapy increased; proportion of infusional/combination chemo and IMP reduced(4)Proportion of dose modifications/reductions were higher, and mostly they were related to COVID-19. Helpline calls were higher during COVID (7% versus 3%), but 38.9% patients who called were not on SACT.	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	UK Coronavirus Cancer Monitoring Project (UKCCMP)	To track cases and outcomes of cancer patients affected by COVID-19 infection in the UK	Ashley Poon-King Clair Brunner	National Project	319 (30·6%) of 1044 patients in the UKCCMP cohort died, 295 (92·5%) of whom had a cause of death recorded as due to COVID-19. The all-cause case–fatality rate in patients with cancer after SARS-CoV-2 infection was significantly associated with increasing age,. Patients with haematological malignancies (leukaemia, lymphoma, and myeloma) had a more severe COVID-19 trajectory compared with patients with solid organ tumours. Compared with the rest of the UKCCMP cohort, patients with leukaemia showed a significantly increased case–fatality rate. After correction for age and sex, patients with haematological malignancies who had recent chemotherapy had an increased risk of death during COVID-19-associated hospital admission.	Reasons for the low intensive care admission rate, which could be due to perceived futility of intensive support in patients with cancer, warrant further investigation.	Our results could be useful to assist physicians in informed risk–benefit discussions to explain COVID-19 risk and enable an evidenced-based approach to national social isolation policies.	Complete
3.1	COVID Radiotherapy: a National Cancer Research Institute (NCRI) CTRad UK-wide initiative	COVID RT is a national initiative that aims to study the impact of COVID-19 and the recovery plan on radiotherapy patients and the radiotherapy service and help us plan for future pandemics	Mererid Evans	National Project	Complete 	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Lung Radiotherapy during Coronavirus Pandemic (COVID-RT Lung)	To understand the changes in radiotherapy services for patient with lung cancer in the UK during the coronavirus pandemic Assess the outcome of operable patients	Ceri Powel Sheena Lam CAD	National Project	Our analysis has limitations as it only includes data from 30 UK radiotherapy centres across the whole of the UK and participating centres had not completed data collection on all treated patients at the time of this initial analysis. We have described the characteristics of patients who had changes to their centre's standard of care management and the regional differences in the management of patients with lung cancer. Our study will provide valuable information to the oncology community to help guide optimal treatment for lung cancer patients going forward.	We have shown that the risk of developing COVID-19 in lung cancer patients receiving radical radiotherapy was low during the first wave of the pandemic, showing that the measures put in place by radiotherapy departments to protect patients were adequate.	An important next step is to report the outcomes of patients treated during the pandemic in order to assess the effect of radiotherapy and chemotherapy adaptations on survival and toxicity. Outcome data are being collected as data matures	Complete
1.1 7.1	Staff COVID-19 testing Pilot questionnaire	To obtain feedback from staff involved on the staff testing pilot	Richard Adams	Users views	Awaiting report	`		Complete
1.1 7.1	Staff Testing pilot	To evaluate the pilot to identify areas of good practice and improvement	Andrea Hague Michael Thomas CAD	Key indicator of practice	Awaiting report			Complete
Integrated Care								
National Audit								

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	UK NACEL Audit	NHS Benchmarking project	SPCT	National Audit		N/A	N/A	Active
Continuous Monitoring – Quality and Safety and Must Do's								
5.1	Single Cancer Pathway – Treatment Pathway Review	Review the treatment pathways for all SST's for patients who receive first definitive treatment at VCC. This will include a retrospective look at what the processes were and how long they took and what the impact of the new pathways will be on service capacity and demand.	SI	National guidelines	Ongoing process	N/A	N/A	Active
6.3	All Wales Patient experience framework	To evaluate patients, experience at VCC to identify areas from improvement	Patient experience	Users views	Ongoing	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	All-Wales Care Decisions for the Last Days of Life Audit	Care Decisions for the Last Days of Life guidance was introduced widely across Wales in 2016. Since then, progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.	CNS	National guidance	All dying patients in VCC are reviewed by the SPCT even if their needs are generalist rather than specialist. 7/7 working continues to ensure pts and junior drs have access and support re last days of life and OOHs there is availability of the Palliative Consultant advice line. Compared to other services in Wales we have high usage of care Decisions guidance.	Areas of good practice	We are keen to move the link nurse programme forward and once the link nurse contracts are approved we will be able to do that. This will further educate and empower ward staff in decision making and best practice art eol.	Ongoing 6 monthly
	Staff Survey: Safeguarding	To establish if staff are aware of the relevant guidelines and support regarding safeguarding within the trust	Safeguarding	Users views				
	Safeguarding documentation audit	To provide measure compliance with the All Wales Safeguarding Procedures.	Safeguarding	All Wales guidelines				
3.1	Immunotherapy for Adjuvant melanoma	To obtain toxicity and outcome data in the adjuvant setting	CNS	Key indicator of practice	Complete awaiting report 07/02/2023 – JA emailed VH 21/02/2023 – JA re-emailed VH	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	CIVICA	Independent service to allow patients to feedback their experiences.	Palliative care	Users views	Recommendations from last year: Restart once restrictions lift. End of Life Care Board are reviewing different methods of Patient Feedback for palliative Care across Wales	N/A	N/A	Ongoing
3.1	Metastatic spinal cord compression (MSCC)	To measure compliance with the standard for referral and assessment for metastatic spinal cord	Physiotherapy	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (6 Monthly)
2.2	Pressure Ulcers	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.3	Slips/Trips/ Falls	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.5	Nutritional Screening including Protected Meal times & fluid balance compliance	To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.5	Mouth care bundles	Ensure compliance with good practice and all Wales standards	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
3.1	Sepsis Six compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Rapid Response to Acute Illness (RRAILS) – National Early Warning Score (NEWS) compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
3.1	Oxygen spot-check	To measure compliance with local/national guidelines	Nursing Ward Manager	Quality assurance	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.4 3.1	Catheter associated Urinary Tract Infections (CAUTI)	To measure compliance with all elements for insertion and maintenance of bundles for urinary catheters	Inpatient Dept. champions	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Weekly)
2.4	Visual Infusion Phlebitis (VIP) Score	To measure compliance with all elements for insertion and maintenance of bundles for peripheral vascular cannula	Ward Manager	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Daily)
2.4	Patient data for MRSA/ MSSA/ C diff/ E Coli/ CAUTI/ Bacteremia	Tier 1 target - To monitor infection rates for all Healthcare Associated Infections (HCAIs)	Nursing Ward Manager & IPC Team	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.4	Methicillin Resistant Staphylococcus Aureus (MRSA) Screening	Tier 1 target - To measure compliance with screening for MRSA	Nursing Ward Manager & IPC Team	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.4	Hand hygiene	Tier 1 target - To measure hand hygiene compliance against World Health Organisation (WHO) 5 Moments of Hand Hygiene	Dept. champions	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Weekly)
2.4	Personal Protection Equipment (PPE)/Isolation	To monitor compliance with PPE (donning and doffing)	IPCT with support from dept. champions	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.9	Environment/ commodes/ sharps/ waste/ linen	To monitor against National Standards for IPC (inclusive of key audits- environmental, commodes/ sharps / clinical practice audits etc)	Infection Prevention & Control	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Annual)
3.1 4.1 5.1	Delayed Transfer of Care (DTOC)	Tier 1 target	Nursing Ward Manager PP	Local & National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
3.1	Chaperone for any intimate examination of gynaecology patients	To audit how many patients we asked re. chaperones pre guidelines and then re-audit after the guidelines were published.	Alison Wyatt	National guidelines Patient safety Local concern	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Annual)
	Record Keeping Audit	Record keeping audit every 6 months to look at compliance to our record keeping guidelines. To then feedback to team and make adjustments/give further education as indicated.	AHP			N/A	N/A	Ongoing Every 6 Months

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Chaperone audit	To ascertain current practice of documentation regarding the offer of a chaperone	CAD	SI/VCC Guidelines				
3.1	Key worker Audit	To review compliance of patients with document key worker	CNS Manager CAD	Key performance indictor				
Breast Malignancies SST								
3.1	Audit of the Pathway for Adjuvant Bisphosphonates in Early Breast Cancer	To ensure all adjuvant breast cancer patients eligible to receive adjuvant bisphosphonate with zoledronic acid are managed safely and equally within the treatment pathway	CNS	NICE Guidelines	Data Collection Stage	N/A	N/A	Active Dec 2022
3.1	Development of an Intravenous Access Decision tool for breast cancer patients receiving Systemic Anti-Cancer Therapy	Develop and implement an intravenous Access decision tool for breast cancer patients about to commence systemic anti-cancer therapy	Nurse	Clinical Effectiveness Service improvement	Complete	N/A	N/A	Complete
Gynaecological Malignancies SST								
	Physio-led Prehab Clinic for gynae-oncology patients – Patient Experience	To evaluate patient's experience of the Gynae Physio-led prehab clinic	AHP	Users/Patient views PREMS	Data collection stage	N/A	N/A	Ongoing June 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Scoping project Patient views on how the service should look	To get feedback from past patients about what the new Gynae-oncology physiotherapy service should look like/offer. Therefore aiming to shape the service taking into account directly patient's views and experiences.	AHP	Users views	Discontinued	N/A	N/A	Discontinued
Lung Malignancies SST								
	Macmillan Lung Cancer Pathway Evaluation	In collaboration with the Macmillan lung CNS, map the existing lung cancer pathway to understand who currently provides supportive care for patients, Design and produce a poster by the end of September for presentation, generate recommendations to improve the lung cancer pathway at VCC for patients.	CNS	Users/Patient views PROMS NICE Guidance Re-Audit Innovation	In interviews, staff and patients identified improvements in person-centred care because of the role. However, these improvements are mainly confined to patients from the two referral hospitals that the Macmillan lung cancer CNS supports. Factors such as staff capacity, staff attitudes and geography have been suggested as potential drivers behind this prioritisation of input. Further work needs to be carried out to understand the significance of this inequality in access for treatment outcomes and thus quality of care. The PDSA cycle and model for improvement may be a useful tool for continuing this quality improvement work.	Areas for improvement	Evidence of positive impacts on the delivery of person-centred care, e.g., acting as a key point of contact for patients on treatment at VCC, supports the continuation of the role. Staff to continue approach of empowering patient to choose which CNS to contact to practice person-centred care and alleviate any possible confusion for patients caused by access to multiple points of contact. Carry out further work to understand how the Macmillan lung cancer CNS' input has been prioritised across patients from local district hospitals and assess	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
							whether these decisions have been made in line with patient needs. Investigate whether ensuring equitable access to Macmillan lung cancer CNS support will improve quality in terms of health outcomes.	
UGI SST								
6.3	Re-Audit Upper GI Patient Survey from 2014	To revaluate the patients experience of the UGI service	CNS	Users views Re-audit	Acknowledged that patients are generally satisfied with information they received. Identified that the survey may need adjustments when carried out next time Overall, majority of patients are satisfied with their experience, and many good areas of practice. Some room for improvement in some areas. Patient care remained at a high standard during COVID pandemic.			Complete
Colorectal SST								
3.1	The incidence of acute onset nausea and vomiting during oxaliplatin infusions	To identify how frequently this is occurring and if we can identify if there are any factors such as dose or number of cycles administered which can help us anticipate which patients are more at risk.	CNS CAD	Clinical Risk	Data Collection stage	N/A	N/A	Active Proposed completion date September 2023
6.3 3.1	Patient support group	support for the CRC cancer patients	CNS	Users views	Data Collection stage	N/A	N/A	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3 3.1	Recovery package and treatment summaries	To ensure all adjuvant patients receive rehab recovery package to enable rehab following completion of treatment. Treatment summary to communicate with patients and primary care – treatment given	CNS	User views Clinical effectiveness	Data Collection stage	N/A	N/A	Ongoing
3.1	Colorectal patient survey	To evaluate Patient experience of the colorectal service	CNS	Users views	Report writing stage .	N/A	N/A	Active Proposed completion date End March 2023
3.1	Anal patient survey	To evaluate Patient experience of the colorectal service	CNS	Users views	Report writing stage .			Active Proposed completion date End March 2023
Head & Neck SST								
6.3	Patient satisfaction Palliative Patients	To obtain patients views regarding the service provided at Velindre	Kate Morgan	Users views	Awaiting report	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	H&N patient Survey	To obtain patients views with regards to the Head and Neck service	CNS	Users views	49% of respondents stated they would find it useful reading about other patient's experiences who underwent similar treatment for head and neck cancers. Some patients also asked for a 'timeline' of appointments and the processes leading up to treatment starting. 73% of respondents stated they would find Personal written record at end of treatment helpful.	End of treatment summaries drafted by CNS' and approved by SST Areas of good practice and areas for improvement identified	Review some aspects of patient information to include feedback received from survey. Support for friends and family. Establishment of a patient support group. End of treatment summaries project.	Complete
	Thyroid Patient Survey	To obtain patients views with regards to the thyroid service	CNS	Users views	Data collection stage	N/A	N/A	Active
Urology SST								
	Patient Survey: Bladder	Collection of baseline data to assess the level of current service provision. This included the development and distribution of a patient survey to research patient preferences for different models of follow-up care and assess the quality of information patients receive before and during their treatment.	CNS	Users views	The majority of patients were either satisfied or very satisfied with their first consultation and discussion of treatment, concerns and needs. The majority of patients felt supported by Velindre and that they received the care that mattered to them. The majority of patients were satisfied with the information they had received, but a significant amount of patients felt they would have liked more information on fatigue management, prognosis, welfare and managing the effects of treatment. Patients demonstrated an significant interest in receiving information virtually (online, video links, electronically, telephone, DVD	Areas of good practice Areas for improvement	Develop treatment plans/summaries to be sent out to patients and GP's post initial diagnosis. Develop and implement recovery package as outlined by Macmillan. E.g. Set up health and well-being seminars that related to Renal and Bladder cancer. Set up a Nurse-Led supportive/ palliative renal cancer clinic. Evaluate the information we currently send out in our 'new patient' packs and the timing of when these are sent out.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Patient Survey: Urology service	To ascertain patients views regarding the urology service following changes in practice.	CNS	Users views	Majority of men were satisfied with their first consultation and discussion of treatment, concerns and needs. The majority of men were satisfied with the care they received from Velindre Cancer Centre.	Areas of good practice Areas for improvement	Navigator will continue to distribute team/key worker information to patients. Navigator will also continue to offer patient opportunity to complete Holistic Needs Assessment (HNA) also promoting awareness of HNA's. Formulate personalised care plan at 6 monthly radiotherapy follow-up appointment. Re-start education seminars Recorded videos of management of side effects and living well after cancer. To put into DVD format and QR code on radiotherapy patient leaflet to then distribute to patients. Develop treatment plans to be sent out to patients and GP's post initial diagnosis. Develop self management patient portal and PSA tracker.	Complete
Other Sites/Services								

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Evaluation of VCC physiotherapy weekend service	The aim of the service evaluation is to quantify how many patient's needs are unmet on a weekend due to the limited service	Therapies	Service evaluation	On average per month, 13 patients receive full intervention, 1 patient is seen but assessment/treatment is not fully complete and 1 patient is seen with assistance of an additional member of staff. 1 patient per month, on average, is not seen at the weekend. After carrying out the service evaluation, we can justify our current staffing levels of one qualified member of staff on Saturday and Sunday. Minimal numbers of patients are only receiving part of their physio assessment or treatment over the weekend and minimal numbers are not being seen over the weekend	N/A	N/A	Complete
3.1	VAPP Project Virtual Generic pre SACT assessment clinics	To reduce capacity in consultant clinics by transferring suitable pre chemo assessment's into a generic clinic.	NMP	Innovation	Now Business as usual (BAU)	Areas of good practice	VAPP to become business as usual and not a project and to expand and become sustainable.	Complete
6.3	Audit on Measure yourself concerns and wellbeing questionnaire	Assess the effectiveness of complementary therapy in cancer care. We aim to use the data in order to begin a research project.	Bethany Lynbeck Keira Gravell	Users views	Staff Members undertaking audit have left the trust, Other staff unaware of Audit.			Discontinued

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Patient acuity on the assessment unit audit		Therapies		151 patients admitted over 21 Days. Level 1 and Level 3 acuity are the most common presentations. 66% of Level 5 acuity patients were admitted due to being 'Sick on site'. 44% Of Level 4 acuity patients were admitted due to being 'Sick on site'. The highest acuity levels were seen between 4pm and 7pm. Highest acuity level patients presented on a Wednesday. The highest number patients in beds were between 1pm and 5pm. Highest number of patients admitted were Monday and Friday. Assessment unit was at capacity or above for 27% of opening hours.	N/A	N/A	Complete
3.1	Patient/carer Self-administration of sub cut injections	To identify numbers of patients attending. Ascertain if these patients could be educated and managed at home. This would reduce patient visits and footfall which at present is even more of a priority due to infection control risks.	Karen Arndell	VCC Guidelines Clinical Risk Clinical Effectiveness Patients views	This project is on hold for the time being until we can find a way of dispensing Denosumab and the resource to continue the assessments. We currently do not have the resource to continue with a chronic short staffing issue but once this is resolved we might be able to pick this back up.	N/A	N/A	On hold

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	A Service Evaluation Project of the Nurse Led Paracentesis/Indwelling Peritoneal Catheter (IPC)	To evaluate the nurse led service and assess whether the service is being delivered within appropriate timeframes. This will also confirm the importance of the service going forward.	Nurse	Key indicator of practice	The collected data, indicates that the majority of patients are, and have been treated for their ascites within 3 days. This demonstrates that the service is effective at seeing patients promptly even when accounting for the impact of Covid-19. This began at the beginning of the evaluation, bringing with it major operational changes and increased staffing challenges. Deeper investigation of the data has however, enabled the author to understand, that the main impact on the waiting times for patients is staffing levels. As the staff levels decrease, the wait times increase.	Service provides prompt good quality care for patients as they are seen with a short wait time from referral.	a)Recruitment of additional ANPs. b)Upskill existing staff c)Provide training to all newly rotating and permanent doctors d)In line with Post Covid-19 recommendations (NHS providers 2020), engage in dialogue with stakeholders to establish cross organisational working with other cancer centres. e)Flexible retirement with options to return to work for trained staff	Complete
3.1	Exploring the definitions of 'value' and 'Value-Based healthcare' in cancer care	Aims to explore how staff define Value-Based healthcare and what they consider to add value to patient care. This will be achieved by conducting semi-structured interviews	Student	Service Evaluation	Awaiting report	N/A	N/A	Complete
3.1	How do organisations support or inhibit high reliability healthcare processes	To investigate what characteristics of Highly Reliable Organisation (HRO) are practiced within the context of healthcare management and how those practises impact on patient safety outcomes and staff outcomes.	Student	Service Evaluation	Awaiting report	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Patient education quality improvement project	The aim of this project is to improve the quality of SACT education received by patients on the Velindre day units	Nurse	Clinical Effectiveness Users/Patient views Patient Safety Local Concern	This project is being taken forward as a research project being supported by the research fellow working with Prof Hopkinson and myself so will no longer require input from the audit team.	N/A	N/A	Complete
	Service Evaluation - Real World Experience of Foundation Medicine Testing at Velindre Cancer Centre	To establish the impact of genetic testing on patient treatment/outcomes, how the requesting process may be improved and how genetic testing might fit in to future practice once the Foundation Medicine pilot is complete	Doctor		Discontinued. CD contacted on numerous occasions email now undeliverable. Unable to get copy of results.	N/A	N/A	Discontinue
	A service evaluation of physiotherapy unscheduled care referrals	A need to better manage and prioritise unscheduled care referrals was identified within the physiotherapy team	Therapies		Audit was on hold due to the changes going on within unscheduled care/ ambulatory care at the moment. It is now felt that it was no longer relevant, will send any updates.	N/A	N/A	Discontinue

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	Audit of the 'pre-booked' admissions to the acute oncology assessment unit	To identify trends in pre-booked referrals to the acute oncology assessment unit. Ascertain if pre-booked patients are appropriate use of the service or if a more suitable alternative solution in available. Analyse the process of referring into the acute oncology assessment unit. Make recommendations to improve the service.	Nurse		Data collection	N/A	N/A	Active
	WAASP Quality Audit	Highlight any inaccuracies in WAASP scoring by comparing WAASP tools completed by nursing staff against how they should be scored based on information from medical notes, nursing documents and patient reports	AHP	Clinical Effectiveness NICE Guidance Patient Safety VCC Guidelines	Data collection	N/A	N/A	Active
SACT & Medicines Management								
Continuous Monitoring – Quality and Safety and Must Do's								
3.1	Niraperib FBC/Toxicity review	To assess patient outcomes	Pharmacy	Key indicator of practice	Pharmacy are collecting this data .	N/A	N/A	Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.6	Medication safety thermometer	To measure compliance of the completion of the 'drug allergy section' on the medication chart against national standards.	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of the VTE risk assessment on the medication chart against national standards.	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of 'medicines reconciliation within 24 hours of admission against national standards.	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure the number of unintentional missed/ omitted medication doses within a 24 hour period against national standards.	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure the number of missed doses for 'high risk medications' against national standards. *High-risk medication includes antimicrobials, anticoagulants, opioids, anticonvulsants and oral SACT.*	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the indication for treatment is documented either on the medication chart / in medical notes	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the duration of treatment is recorded either on the medication chart / in medical notes	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the antimicrobial is prescribed in accordance with the trust guidelines / C&S or following microbiology advice	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether a senior review was carried out at 48 / 72 hours, and documented on the medication chart / medical notes (including outcome of review).	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)
2.6	Hospital Acquired Thrombosis	WG Tier 1 target – To identify the number of potentially avoidable Hospital Acquired Thrombosis (HATs)	Pharmacy	National Guidelines	Figures are reported regularly. A summary will be provided for the next annual report	N/A	N/A	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Implementation of the 'Antibiotic Review Kit (ARK) Project' into VCC	To provide assurances around antimicrobial stewardship. These measures aim to provide re-assurances that prescribing practices are in line with best practice.	SpR	Key indicator of practice VCC Guidelines 1000 Lives	Data collection stage	N/A	N/A	Active Proposed completion date June 2022
3.1	Snapshot audit of the use of DPYD in clinical decision making.	To inform the future delivery of this important service	Pharmacy	National audit				
Radiation Services Care Directorate								
3.1	Is the occurrence of Radiotherapy Human Error related to Group Affective processes within the Radiotherapy team?	To explore affect and group affect processes within the specific Radiotherapy team following a human error	Paul Jenkins	Patient safety	Data collection	N/A	N/A	Active Proposed completion September 2023
3.1 5.1	CT PA requests	To create a robust pathway for suspected PE	Radiology		Data collection	N/A	N/A	On going
3.5	Local Safety Standard for Invasive Procedure (LOCSSIP)	To evidence of compliance with the WHO Surgical Safety checklist and VCC/NICE guidelines	Radiation services	NICE Guidance WHO	Ongoing data collection	N/A	N/A	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1 5.1	MRI Spine requests	To create a robust pathway for suspected MSCC	Radiology		This is a retrospective review of MRI spine request forms received between August 2020 and January 2021. This does not include follow up and baseline scans. During this period 70 MRI spine scans were performed. Patients were referred for scans from the following locations: Outpatients, Assessment unit, VCC wards. Within the clinical information 53 request forms stated ?Metastatic Spinal Cord Compression (MSCC) 18 patients were diagnosed with MSCC on MRI.	N/A	N/A	Complete

AUDIT COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	26.07.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the Audit Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust. • Summarise the final phase in implementing the Risk Framework.

RECOMMENDATION / ACTIONS	The Audit Committee is asked to: • **NOTE** the risks level 20, 16 and 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTE** the on-going developments of the Trust's risk framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
EMB Run	29.06.2023
Quality, Safety and Performance Committee	13.07.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Discussion around the length of time risks are open versus the risk rating took place. This issue will be considered in the next cycle.	

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

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

APPENDICES	
1	Current risk register data.
2	Risk data graphs

1. SITUATION

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

2. BACKGROUND

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

3. ASSESSMENT

3.1 Trust Risk Register

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

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Risk Register

- The risk register detail in Appendix 1 is for consideration by the Audit Committee.
- Considerable work has been undertaken to ensure each risk has an action plan. The action plans are continually under review in divisions with transition to SMART. All risks reported in this report now have action plans in place.
- To note all actions in the Datix action plan section have assigned owners – however given named individuals on the system, this is not included in reporting. If any member would like further details, this can be provided.
- All risks reported are on target with review dates.
- An audit of risk titles has been carried out and titles amended as per the naming conventions on Datix where appropriate. Some risk titles are nationally agreed and remain unchanged on Datix.
- There was discussion in Executive Management Board on what are the key gaps in achieving a level 3 level of assurance, which is defined as "Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed." There was an in-depth discussion on given the length of time some risks are

open at a high residual score. This suggests actions are not addressing root causes effectively in these cases and this will be the area of focus for the next cycle.

4.2 Risk In Depth Review

At Quality, Safety and Performance Committee on 13.07.2023 an in depth review if two risks took place, 3001, Workforce risk, and 3042, Laboratory Information Management System (LIMS).

The length of time risks were open versus the lack of movement towards the target risk was raised and agreement reached that the focus in the next cycle of review would include this.

The need to demonstrate month on month management towards reaching target risk rates was discussed.

4.3 Digital Risks

In consideration of risks at Quality, Safety and Performance Committee there was a request to reflect on risks relating to digital systems. Following review of the risks there are no evident trends in digital risks; individual risks related to digital development are unique to each system.

In depth discussion took place in respect of risk 3042, LIMS, which relates to service provision as a result of maintaining a legacy system. The contract is currently moving through the governance system for approval.

Risk 3011 has been closed following review at the DHCR Operational Group, the detail of this risk can be viewed on the risk register in appendix 1.

Risk 2465 relates to email traffic; work is underway to reduce the amount of email traffic and duplication. The Head of Information Governance has launched an audit of the use of email in clinical decision making, which commenced on 17.07.2023. The full scope of the audit remains flexible with an estimated completion date of 04.08.2023.

4.4 Next Steps in Engagement and Embedding

- The approved Policy and Procedure are now on the intranet, with links on both divisional intranet pages.
- The Datix 'How To' guide has been updated and can be accessed via the intranet: DATIX How To Guide
- Level 1 mandatory training for all staff has been live in individual ESR Learning Matrixes, as of 17th April 2023. Initial management of completion

of training will be tracked via the Trust risk weekly meeting and reported into Executive Management Board.

- As of 23rd June 2023 an Introduction to Risk training has a completion rate of 53.70% across VCS, WBS and Corporate.

Compliance Area	Compliance Rate
Corporate	49.7%
Research Development and Innovation	56.0%
Transforming Cancer Services	48.0%
Velindre Cancer Centre	51.3%
Welsh Blood Service	60.4%

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

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains.
	Safe ☒
	Timely ☒

	Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required
	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.
	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following:

	Source of Funding: Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text. **Type of Funding:** Choose an item. **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text. **Type of Change** Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text.

6. RISKS

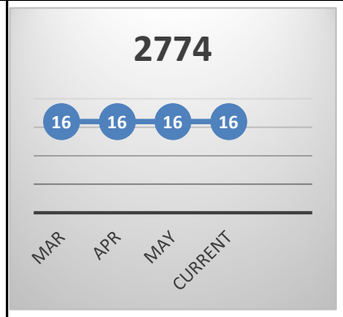
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require further work.

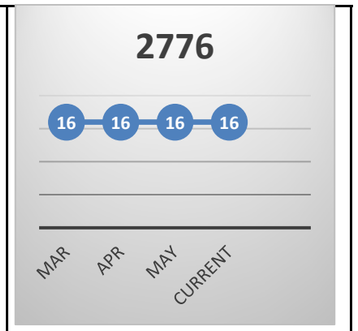
BY WHEN?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

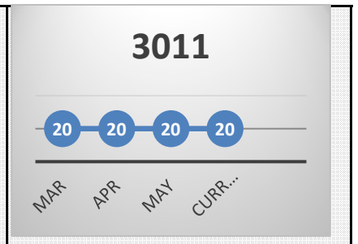
APPENDIX 1

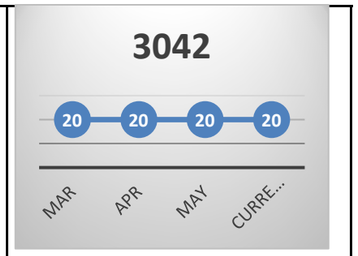
Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

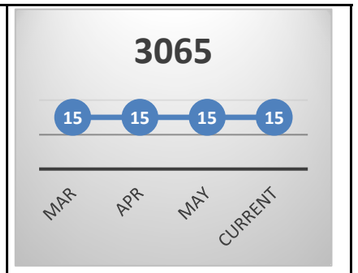
RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions,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

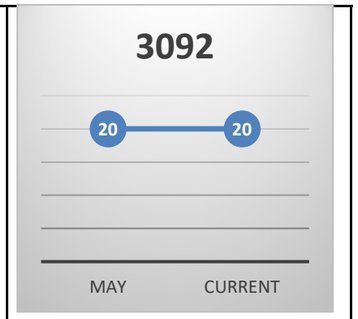
ID	Risk Title - New	Risk Type	Opened	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Plan	Days Open	Risk Trend
2774	There is a risk to quality/complaints /audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Welsh Blood Service	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety.	16	4	01/09/2023	Complete actions for replacement LIMS - see risk 2776 Individual Actions recorded in risk 2776: Secure Funding by 28/04/2023 Tender for replacement LIMS by 31/05/2023 Implement replacement LIMS by 31/07/2024 Report to the Laboratories Digital Transformation Board Due date 31.07.2024	273	

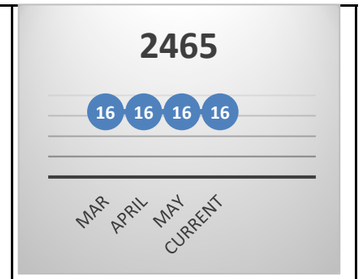
2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders requests.	16	4	01/09/2023	Tender for replacement LIMS Completion of Procurement Brief, URS and supporting documentation. Issue of tender. Report to Laboratories Digital Transformation Board. Update 06/06/2023 - "Due date" extended to 30/06/2023. Tender has been delayed due to other projects being prioritised by Procurement. New estimated timeline proposed by Procurement is to go out to tender by end of June. Due date 30.06.2023 Implement replacement LIMS Report to Laboratories Digital Transformation Board	273	

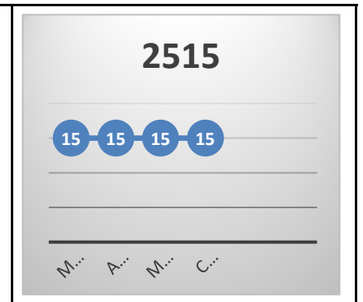
3011	There is a risk to the safety of patient care as a result of delays in scheduling patient appointments due to a technical error in the processing of Outpatient Oncology Note Outcomes leading to possible harm.	Safety	22/12/2022	Velindre Cancer Centre	Immediate escalation to DHCW for investigation. Identified bugs to be resolved. DHCW to extend the Contractor to apply identified development to support resolution of issue. Rewrite the VCC import process to complete a full reconciliation between what is held by DHCW and what is held by VCC each refresh Additional support to be identified and put in place to process and book all patient activity. Patients to be contacted by telephone and verbally advised of appointment due within 14 days to reduce risk Phlebotomy to be completed at VCC to reduce risk of delay to treatment (where the next appointment is scheduled to take place within 14 days)	Technical failure of the data shredding process within the national service has meant that not all clinic outcome instructions are being made available within the Outpatient Oncology Note Report, and therefore not acted upon.	15	5	30/06/2023	Digital Health Care Wales (DHCW) will be applying a fix/development that will prevent a delay/restart of the servers following automated regular up-dates. This has previously stopped/delayed the shredding process taking place. Delays encountered due to bugs identified during the UAT period. Further development work required with an amended delivery date of 14.07.23. DHSW to maintain communication/up-dates.	217	 This risk has now been closed - 18.07.2023 - following a system adaptation the risk was reviewed and outstanding actions completed and reviewed by the DHCR Operation Group, who approved the risk for closure. The progress has been updated on Datix.

3042	There is a risk to performance IF the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025 THEN operational delivery of pathology services may be severely impacted RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact. **NATIONAL LINC RISK**	Performance and Service Sustainability	07/02/2023	Velindre Cancer Centre	Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	The current (InterSystems) contract for TrakCare Lab is due to end in June 2025. The LINC programme has been established to deliver a replacement all-Wales LIMS system - the contract has been awarded to Citadel Health. VCC pathology services are provided to Velindre by C&V ULHB. If the Citadel Health solution is not deployed into C&V UHB before June 2025, there is a risk to service delivery for the C&V-managed pathology laboratory. The national DHCW / LINC programme team have requested this risk be recorded on all HB/Trust risk registers, to ensure appropriate visibility and ongoing monitoring.	20	5	07/08/2023	Active ongoing engagement in national programme. Confirmation of internal governance and escalation process across the Trust.Due date: 30.06.2025	170	

3065	There is a risk to COMPLIANCE as a result of the permanent deletion of email mailboxes for VUNHST staff who have fully left the NHS since September 2021, leading to a potential issue should those emails be required by a 3rd party investigation - e.g. COVID enquiry.	Compliance	10/03/2023	Corporate Services	Upon identification of the incident, DHCW have put in place temporary measures - effective from 17/02/2023 - to prevent further deletion of mailboxes for staff leaving the NHS Wales. DHCW are also engaging with Microsoft to explore what, if any, opportunity there is to retrieve the deleted emails/mailboxes.	NHS Wales deployed O365 in July 2019. The national tenancy was established with the intention of ensuring emails / mailboxes for staff who left the NHS (i.e. there O365 account was closed) would be retained for a 7ear year retention period, as per the national NHS Wales Email Policy. Investigations prompted by an enquiry by C&V UHB in February 2023 confirmed that this policy was not what was configured on the NHS Wales tenancy. As such, any emails / mailboxes for staff who have left the NHS will have been deleted after 30 days of account closure, unless another form of manual 'hold' was in place on the account. In VUNHST, 'litigation hold' was in place by default on all accounts up to 22/09/2021, when a national change was made to remove litigation hold for VUNHST O365 accounts. As such, the risk for VUNHST is that staff who have left NHS Wales in the period 23/09/2021 - 17/02/2023 will be that emails for those staff will not be retrievable for (e.g.) FoI, evidence for COVID-19 enquiry etc.	15	3	01/08/2023	Review staff list to assess impact of mailbox deletion for VUNHST O365 accounts. List of impacted mailboxes has been produced by Digital Services - to be reviewed by Head of IG & Head of Digital Delivery to assess overall impact of deletion. List of impacted mailboxes has been produced by Digital Services Due date 30.06.2023	139	

3092	there is a risk that patients may receive inappropriate management/treatment as a result of inaccurate manual data entry into WPAS/EIRRMER following implementation of DHCR leading to patients being allocated to an inappropriate treatment pathway/clinician.	Multiple Risk Domains	27/04/2023	Velindre Cancer Centre	- A series of deep dives to understand problem areas have been undertaken - Clear actions plans have been developed across directorates - An operational management group have been stood up to oversee delivery of actions and determine wider trends, reporting to the Business Planning Group (BPG) and Senior Leadership Team (SLT) - Refresher training being provided across VCC	there is a risk that patients may receive inappropriate management/treatment as a result of inaccurate manual data entry into WPAS/EIRRMER following implementation of DHCR leading to patients being allocated to an inappropriate treatment pathway/clinician.	20	8	31/07/2023	summary of actions required by clinicians to address data quality issues with WPAS being collated and will be shared via SMSC in June. Due dte 31.07.2023	91	
3139	Clearance Limitations There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	Performance and Service Sustainability	21/06/2023	Transforming Cancer Services	1) Application to be clear on expected plan for clearance works 2) Alternative plan should limitations be put in place 3) Sceure 3rd party opinion on clearance	There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	15	6	10/07/2023	1) Application to be clear on expected plan for clearance works 2) Alternative plan should limitations be put in place 3) Secure 3rd party opinion on clearance 1) application has been submitted stating the anticipated planned clearance areas and schedule to provide NRW with clear view of works including habitat creation requirements Due date 10.7.2023	36	NEW RISK - NO TREND DATA

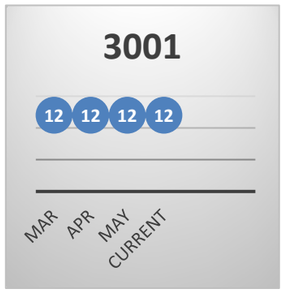
3140	EPSL Application Approval There is a risk that the EPSL application will not be approved or takes longer than planned to be approved by the NRW leading to delays to required clearance or miss the clearance window causing approx 6 month further delay.	Performance and Service Sustainability	21/06/2023	Transforming Cancer Services	1) Resolution of habitat management matters to provide NRW with assurance they require 2) Respond to any queries as a matter of priority 3) Liaise with Cardiff Council to agree approach 4) Work with WG to intervene if required 5) Maintain Actions Tracker	There is a risk that the EPSL application will not be approved or takes longer than planned to be approved by the NRW leading to delays to required clearance or miss the clearance window causing approx 6 month further delay.	15	6	30/06/2023	1) Resolution of habitat management matters to provide NRW with assurance they require - ongoing 2) Respond to any queries as a matter of priority - ongoing 3) Liaise with Cardiff Council to agree approach - ongoing 4) Work with WG to intervene if required - ongoing Due date: 30.06.2023	36	NEW RISK - NO TREND DATA
2465	There is a risk to safety as a result of significant increase in email traffic leading to critical emails being missed or not responded to in a timely manner leading to patient care and staff well being	Safety	05/11/2021	Velindre Cancer Centre	staff reminded to be considerate when 'replying to all'	There is a risk of missing critical emails especially critical clinical questions due to the volume of emails. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	4	30/06/2023	An audit/survey to be undertaken to identify themes in order to determine how best to minimise taking into account clinical and service needs. Due date: 30.06.2023 email etiquette to be developed as part of hybrid working tool kit and shared widely. Due date 30.06.2023	629	

2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	Performance and Service Sustainability	09/02/2022	Velindre Cancer Centre	Service provision across all specialties is managed by careful examination of rotas and managing leave within the teams. Clinical Oncology: One Consultant Urologist is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. One Speciality Doctor was appointed to Gynae Oncology Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence. Radiotherapy: Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team.	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service. Clinical Oncology: There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience. A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST Radiotherapy: Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover. Time demands from DXR administration and treatments conflict with brachytherapy service provision and training.	15	15	30/09/2023	to improve resilience in MPE service training of further brachy MPE. Prioritised by Head of Service. Target completion date 31st July due date: 31.07.2023 workforce review in Q1/2 2023 to look at demand for next 5 years. Due date: 31.09.2023	533	

					A training schedule for staff is in place to ensure increased resilience from cross cover of tasks. A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC. Theatre: Staffing hours have been increased (March 2023) to improve resilience of the service provision. Training plans are under consideration to further increase resilience through cross cover of tasks. Vacant HCA post was filled (March 2023). Physics: A training plan is under implementation to increase the	Theatre: One member of the team is currently on long term sick. Return to work due May 2023. Physics: Currently two Brachytherapy MPEs appointed. A recent resignation (April 2023) of a staff member in MPE training and one MPE due to start maternity leave in July 2023 has left the service vulnerable to a future MPE single point of failure. This could lead to service discontinuity.						

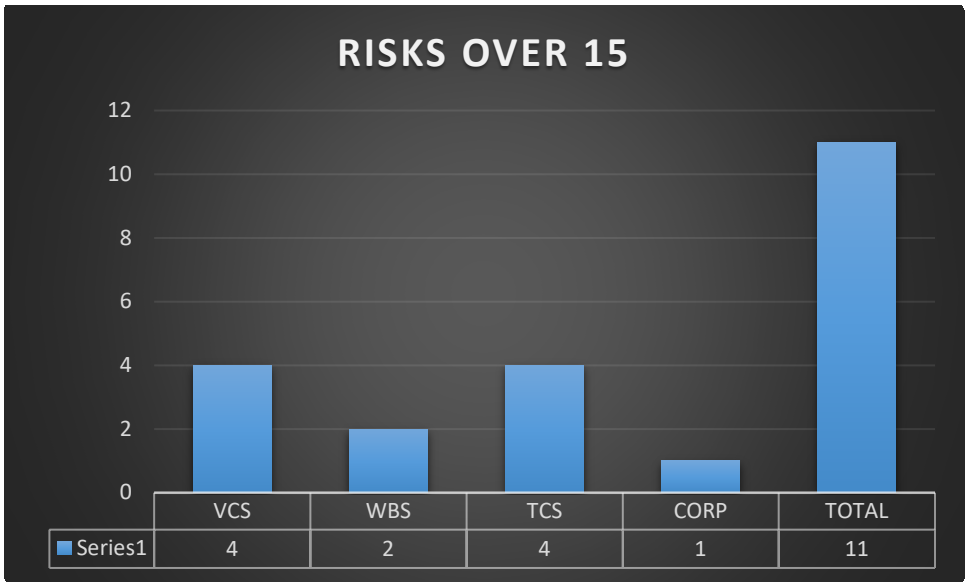
implementation to increase the number of Brachytherapy MPE and Registered Clinical Scientists competent to perform MPE duties under written guidelines and supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service.

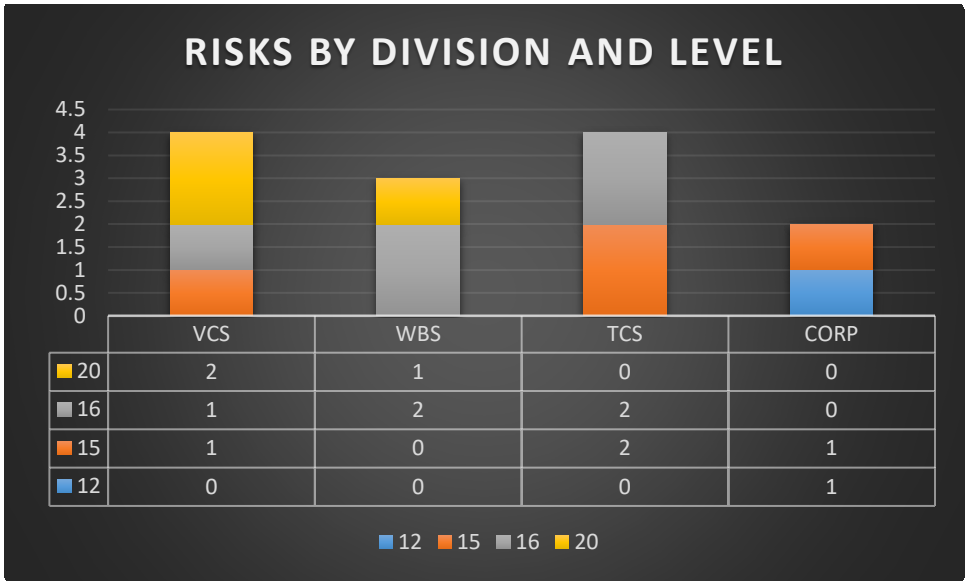
Future Planning:
An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service model to meet forecast demand over a 1 to 5 year period. A workforce paper will be drawn up to staff the model to include resilience and succession planning. A business case will be submitted if required. Staff model completion due

ID	Risk Title - New	Risk Type	Opened	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Plan	Days Open	Risk Trend
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	Safety	09/12/2022	Corporate Services	Policies and Procedures Managing Attendance @ Work Policy, Training and Toolkit Respect and Resolution Policy, Training and Toolkit Equality, Diversity and Inclusion Policy Managing Organisational Change Policy and Toolkit Hybrid working Flexible working Job descriptions/PADR process Training Development of 'Building our futures together programme' – Leadership Development, Behaviours, Compassionate Leadership Training and education managers on compassionate leadership (Inspire Programme) Access to internal and external training/career development Online resources Wellbeing and Engagement online resources Work in Confidence Platform External awards Corporate Health Standard Platinum Award Time to Change Wales signatory Monitoring of staff wellbeing Annual Staff Engagement Survey Monitoring of sickness absence figures by Board External wellbeing audits Organisational support Staff networks Occupational Health Employee Assistance Programme Mental Health First Aider network Access to Complementary therapy Mindfulness App Individual Stress risk assessments completed by manager Purchase of annual leave Financial advice, Salary sacrifice schemes	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. HSE defines stress as 'the adverse reaction people have to excessive pressure or other types of demand places on them'. Staff employed by the Trust have a wide variety of roles including clinical and non-clinical, administrative support and patient/donor facing. Work in carried out at VUNHST premises, donation venues, in outreach centres. Some staff work in an agile way, working both at VUNHST premises and other locations including at home. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work. Not all of this will be work related. The risk relates to all Trust employees HSE identifies six main areas that may lead to work-related stress if not properly managed: demands, control, support, relationships, role and change. Demand – workload, ability to do work required, conflicting priorities, work patterns, physical environment and violence and aggression. Control – pace of work and ability to take breaks. Development and use of professional skills. Support – lack of support for staff from managers and colleagues. Staff not know what support is available and how to access it. Relationship – negative behaviours, interpersonal and/or inter-team conflict, perceived unfairness. Bullying. Poor communication. Resolution procedures not accessed in a timely way. Role – lack of clarity and communication	12	9	30/06/2023	Divisions/Departments do not all have proactive stress risk assessments Healthy and Engaged steering Group to communicate with Divisions and Departments about stress risk assessments by 30 June 2023. To be monitored by the Healthy and Engaged Steering Group Due date: 09.12.2023 The Trust needs to use evidence to determine what the organisational factors are that are impacting on levels of stress on individuals. These factors need to be understood and communicated. Plans in those areas of work already in place need to be aligned to this risk or new plans developed. The work plan derived from this should sit under the 'Building Our Future Together' Portfolio. Due date 22.12.2023	230	

					Financial advice, Salary sacrifice schemes. Blue light discounts. Car lease scheme. Cycle to work scheme Wellbeing activities/events Wellbeing rooms/facilities Healthy and Engaged Steering Group Clinical Psychologist for staff and teams – including proactive programme of engagement. Dialogue with Trade Unions	Role – lack of clarity and communication around roles and responsibilities. Change – lack of communication or poorly understood communication about proposed changes. Lack of support for staff during periods of change. Home/family/personal issues which may add to stress at work					

Overall Risk Data




RISKS BY DIVISION AND LEVEL
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
VCS WBS TCS CORP
20 2 1 0 0
16 1 2 2 0
15 1 0 2 1
12 0 0 0 1
12 15 16 20

AUDIT COMMITTEE

AUDIT REPORT OVERDUE AND COMPLETED RECOMMENDATIONS ACTIONS

DATE OF MEETING	26/07/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Chris Moreton, Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Audit Committee on reported progress against audit report recommendations and identified management actions.
RECOMMENDATION / ACTIONS	**RECOMMENDATION** • The Audit Committee are asked to **NOTE** the contents of the report and the assurance it provides regarding the activities undertaken to

	address audit recommendations in response to audit report recommendations and associated risks. • The Audit Committee are asked to **APPROVE** 24 Internal Audit Report actions (43%) and 6 External Audit Report actions (60%) that have been completed since the April '23 Audit Committee **(Green Status).** If agreed these actions will be formally Closed **(Blue Status).** ***To note - 9 of these actions have been approved to change to Closed (Blue Status) through a Chairs Urgent Action but these were not taken to 29 June '23 EMB.*** • 3 Internal Audit (5%) and 2 External Audit (20%) Audit Report actions have passed the agreed implementation date **(Red Status).** The Audit Committee is asked to **APPROVE** the extension dates identified.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run - The full version of the Audit Action Tracker was taken to Executive Management Board with the 'June 2023 Updates' to provide an update to the Executive Management Board on reported progress against audit report recommendations and identified management actions. The Executive Management Board **NOTED** the Recommendations / Actions provided in the report.	29/06/2023
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE

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

APPENDICES	
Appendix 1	Red Overdue Recommendations Actions
Appendix 2	Audit Action Tracker – Updated June 2023 – 29 June 2023 Overdue/Red and Complete/Green

1. SITUATION / BACKGROUND

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

1.2 Following the April '23 Audit Committee, and May '23 and 05 June '23 Executive Management Board further updates from Action owners on implementation progress were sought on the 6th June 2023 requesting a response by the 15th June 2023. Responses have been added to the 'June 2023 Update' columns in the Tracker. Any further extensions to implementation dates were also requested to be provided in the 'Requested Extension Date' and 'Extension (Months)' columns of the Tracker.

1.3 This report focuses on the status of all actions and Audit Committee is requested to consider the contents of the report and the attached action plan.

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Context

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

2.1.2 To aid forward planning, 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
June	15 June 2023	29 June 2023	26 July 2023
July	12 July 2023	31 July 2023	
August	16 August 2023	31 August 2023	

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

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

2.2 Internal Audit Actions Analysis

2.2.1 4 Internal audit reports were added to the Audit Action Tracker following the April '23 Audit Committee and consisted of 16 Matters' arising. In response to these Matters arising management identified 24 recommendations / actions in total, of which 15 were medium priority, 9 low priority and 0 high priority. The 4 reports added were:

Clinical Audit (Velindre Cancer Centre) Final Internal Audit Report
Information Governance Final Internal Audit Report
Capital Systems Final Internal Audit Report
Cyber Security Final Internal Audit Report

2.2.2 Work undertaken by Management / Officer leads to complete actions since the April '23 Audit Committee has resulted in 24 Internal Audit actions being completed.

2.2.3 The table below provides a summary of the movement in total internal audit actions from April '23 Audit Committee to 26 July '23 Audit Committee.

Internal Audit Report Actions					
	TOTAL ACTIONS	**HIGH**	**MEDIUM**	**LOW**	**N/A**
April '23 Audit Committee					
Total Outstanding Actions	72	5	39	28	0
Less: Completed Actions (Green) – Agreed to close (Changed to Blue)	(40)	(3)	(25)	(12)	0
Following April '23 Audit Committee					
Total Outstanding Actions	32	2	14	16	**0**
Add: Total Actions from new reports taken to April '23 Committee	24	0	15	9	**0**
Total Outstanding Actions	**56**	**2**	**29**	**25**	**0**
Total Completed Actions (Green) – propose close (Blue) @ 17 May '23 (Update May 2023)	15	1	7	7	0
Total Completed Actions (Green) – propose close (Blue) @ 16 June '23 (Update June 2023)	9	1	7	1	0
Total Completed Actions (Green) - propose close (Blue) at July '23 Audit Committee	**24**	**2**	**14**	**8**	**0**

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

June '23 – Internal Audit

Priority	2022/23	2023/24	Total
No. of Audit Reports	21	4	**25**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	32	24	**56**

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 May 2023	Action complete June 2023	Closed
High	2				1	1	8
Medium	29	2		13	7	7	81
Low	25	1		16	7	1	51
N/A (Advisory Audit)	0						10
Total (- Blue Status Actions)	**56**	**3**	**0**	**29**	**15**	**9**	150
% (- Blue Status Actions)	**100%**	**5%**	**0%**	**52%**	**27%**	**16%**	**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 May 2023	Action complete June 2023	Closed
Executive Director of Finance	11	2		6	3		52
Director of Strategic Transformation, Planning & Digital	16			14		2	17
Director of Governance & Chief of Staff	0						20
Director of Nursing, AHPs & Health Science	4	1		3			4
Director of OD and Workforce	0						8
Chief Operating Officer	3			1	1	1	27
TCS nVCC Project Director	9				9		10
Executive Director of Finance and Chief Operating Officer	0						2
Chief Operating Officer and Director of Governance & Chief of Staff	0						10
Executive Medical Director	12			4	2	6	
Director of Strategic Transformation, Planning & Digital and Executive Director of Finance	1			1			
Total	**56**	**3**	**0**	**29**	**15**	**9**	150

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

Priority	2021/22	2022/23	Total
High			
Medium		2	2
Low		1	1
N/A (Advisory Audit)			
Total		**3**	**3**

2.2.5 There are 3 actions (5%) for which the implementation date has passed and management action is not complete (Red).

2.2.6 There are 24 actions (43%) since the April '23 Audit Committee that have been completed.

2.2.7 There are 29 actions (52%) 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 One External audit reports was added to the Audit Action Tracker following the April '23 Audit Committee and consisted of 5 Matters' arising. In response to these Matters arising management identified 9 recommendations / actions in total which were all High Priority. The one report added was:

- Structured Assessment 2022 – Velindre University NHS Trust

2.3.2 Management / Officer leads have completed 6 further actions since the April '23 Audit Committee.

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

June '23 – External Audit

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

Priority	2022/23	2023/24	Total
No. of Audit Reports	6	1	**7**
No. of Actions Outstanding i.e., not yet agreed by Audit Committee to CLOSE	1	9	**10**

Action Status by Prioritisation Timescale

Priority	Total	Implementation date passed - Action not complete	Action not on target for completion by agreed date	Action on target to be completed by agreed date	Action complete May 2023	Action complete June 2023	Closed
High	9	1		2	4	2	3
Medium	0						3
Low	0						2
N/A (Advisory Audit)	1	1					34
Total	10	2	0	2	4	2	42
%	100%	20%	0%	20%	40%	20%	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 May 2023	Action complete June 2023	Closed
Executive Director of Finance	0						10
Director of Strategic Transformation,	6	1		1	2	2	
Director of Governance & Chief of Staff	2			1	1		19
Director of Nursing, AHPs & Health	2	1			1		
Director of OD and Workforce	0						9

Chief Operating Officer	0							2
Director Corporate Governance and Chief of Staff and Executive Director Nursing, AHP and Health Science.	0							2
Total	**10**	**2**	**0**	**2**	**4**	**2**		**42**

2.3.4 There are 2 actions (20%) for which the implementation date has passed and management action is not complete (Red).

2.3.5 There are 6 actions (60%) are identified as compete (Green).

2.3.6 There are 2 actions (20%) that are not yet due and are on target for completion by the agreed date (Yellow).

2.4 Summary of the position as of 26 July 2023:

- 24 (43%) Internal Audit Report actions and 6 (60%) External Audit Report actions have been completed **(Green Status)** and will be requested to be changed to closed (Blue Status) at the July '23 Audit Committee.

To note 9 of these actions have been approved to change to Closed (Blue Status) through a Chairs Urgent Action which is included in the July '23 Audit Committee Agenda.

- 29 (52%) Internal Audit Report actions and 2 (20%) External Audit Report actions are on target for completion by the agreed date **(Yellow Status).**

- 3 (5%) Internal Audit Report actions and 2 (20%) External Audit Report actions that have passed their agreed implementation date (**Red Status**).

3. IMPACT ASSESSMENT

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

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *There are no specific quality and safety implications related to the activity outlined in this report.* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Not applicable for this report **Source of Funding**: **Choose an item**

	Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required *Not applicable*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. **Click or tap here to enter text**

Appendix 1.

Overdue /Red Actions / Recommendations.

Internal Audit:

Finance & Service Sustainability: Budgetary Control & Savings Plans					Assurance Rating: Reasonable			Date Received at Audit Committee: 04 October 2022								
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update November 2022	Update December 2022	Update January 2023	Update February 2023	Update March / April 2023	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
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 Collandris, Head of Financial Planning & Reporting	30.04.2023	Overdue	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.	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.	The COO and Trust directors delegation letters have been issued. Due to sickness and vacancies through the finance team there is a request to extend the deadline for sub-delegation letters to be issued.	Remaining DECL letters on course to be issued by requested extension date.	30th June 2023	2 months
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 Collandris, Head of Financial Planning & Reporting	30.04.2023 To Note: Date amended from 30.01.2022 as error on Audit Report.	Overdue	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.	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.	FCP has been updated but will require from governance route approval. Extension to enable formal approval through audit committee is requested.	FCP to be summited to EMB in June for endorsement and formal approval of audit committee in July.	31st July 2023	3 months

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	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
	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	Overdue	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.	Civica have confirmed their work on this will be completed by 19/05/2023. Emma Powell Has asked The BI Team to work on this once the link is established. Nicola Williams is agreeing measures. Need development time to build the ETL to bring the data in, the measures require from that data and then testing and UAT so extension is requested until end July 2023.		21-Jul-23	3 Months

External Audit:

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	Update May 2023	Update June 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 Extension Request Agreed April 2023 Audit Committee: 30 April 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.	Four of five priorities agreed, aligned with Safe Care Collaborative Priorities. Measurable outcomes are beng determined.	Four of five priorities agreed, aligned with Safe Care Collaborative Priorities. Measurable outcomes are beng determined.		1 Month

External Audit Report - Structured Assessment 2022 - Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 25 April 2023			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
Recommendation 5	**Improving reporting on the benefits arising from digital investments** Whilst there is good reporting on progress in delivering key digital projects and programmes, the reports do not provide an assessments of what difference they are making, whether they are sufficiently recourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.	High	The further development of digital benefits will be undertaken in several ways: (i) a range of key performance indicators that are reported to the Executive Management Board	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	31st May 2023	Overdue	The Performance Management Framework includes the agreed current Digital measures. QSP have agreed which measures are to be brought forward to Board committee level (Cyber Security compliance and IT Business Continuity). The QSP Digital Report (presented in May '23 had its format changed to show the intended benefits for each of the digital activities). We will continue to develop this format for future reports.	Initial set of digital measures have been implemented into the performance management framework to EMB in May/June 2023		

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

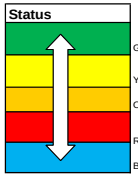
Priority	
Low	< 3 months *
Medium	< 1 month *
High	Immediate *

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

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 for July 2022 Committee	Update March / April 2023	Update May 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	Complete			Cycles of business appropriately mapped through internal Trust and joint WG governance.		
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	Complete			Cycles of business appropriately mapped through internal Trust and joint WG governance.		

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 February 2023	Update March / April 2023	Update May 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 business case 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	Complete			All regular reports indicated now received by Project Board - with appropriate reporting into Strategic Capital Board and TCS Scrutiny Sub-Committee.		
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	Complete			Business Case development and approval appropriately mapped through internal governance structures.		
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	Complete			Reporting on Gateway actions appropriately mapped through internal governance structures		
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	Complete			PID completed.		

Audit Action Plan

Velindre UNHS Trust

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

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

* Unless a more appropriate timescale is identified / agreed

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 February 2023	Update March / April 2023	Update May 2023	Requested Extension Date	Extension (Months)
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	Complete			Full risk and issue register for Projects 1,2 and dependencies between all projects managed appropriately through project governance.		
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	Complete			Reporting appropriately to Audit Committee.		

Audit Action Plan

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

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

* Unless a more appropriate timescale is identified / agreed

Velindre UNHS Trust

Finance & Service Sustainability: Budgetary Control & Savings Plans					Assurance Rating: Reasonable			Date Received at Audit Committee: 04 October 2022				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update March / April 2023	Update May 2023	Update June 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 Collandris, 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	Complete	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	**COMPELTE** The IMTP was approved by the Board on the 30th March and subsequently submitted to WG on the 31st March.	n/a	n/a	n/a
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 Collandris, Head of Financial Planning & Reporting	30.04.2023	Overdue	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	The COO and Trust directors delegation letters have been issued. Due to sickness and vacancies through the finance team there is a request to extend the deadline for sub-delegation letters to be issued.	Remaining DECL letters on course to be issued by requested extension date.	30th June 2023	2 months
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 Collandris, Head of Financial Planning & Reporting	30.04.2023 To Note: Date amended from 30.01.2022 as error on Audit Report.	Overdue	In line with the agreed implementation date this will be picked up as part of 2023/24 budget setting exercise.	FCP has been updated but will require from governance route approval. Extension to enable formal approval through audit committee is requested.	FCP to be summited to EMB in June for endorsement and formal approval of audit committee in July.	31st July 2023	3 months
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
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 monthly 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 Collandris, 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 Collandris, 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	Capacity issues in the finance team have delayed implementation, however this remains on target to be completed in line with the agreed revised implementation date.		9 months

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 March / April 2023	Update May 2023	Update June 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	Action Closed	**Complete.** Managing Attendance at Work Trainign is recorded in ESR and each manager can view their team members' compliance through the ESR Dashboard. This will enable them to monitor compliance.			Extention 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 Extension request agreed April 2023 Audit Committee: 30 April 2023. The Workforce Development Manager post is vacant and this review will take time out of another team member's work therefore an extension to 30 April 2023 wil allow the work to be completed as required.	Complete	A standardised evaluation form will be introduced for all in-house management courses in April 2023	**Complete.** An evaluation form is now in place.	**n/a**	30 April 2023. The Workforce Development Manager post is vacant and this review will take time out of another team member's work therefore an extension to 30 April 2023 wil allow the work to be completed as required.	4 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	Action Closed	**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	Action Closed	n/a			n/a	n/a

Audit Action Plan

Velindre UNHS Trust

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

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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 March / April 2023	Update May 2023	Update June 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	Action Closed	**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. Guidence now been provided to Senior Managers and is being cascaded in colaboration with Workforce.				
Ma	**Demonstrating compliance with the MAAW Policy (Operation)** 3.1 Remind line managers of the importance of: • timely storage of absence records in the appropriate location, which is accessible in their absence, including the information noted as outstanding in this audit (a detailed list has been provided to management); and • ensuring absence records contain sufficient information to justify decisions made and actions taken, including for short-term absences, delays in LTS meetings, application of discretion, and discussions around sustained attendance / returning to work.	High	Develop key messages for SLT/SMT members, for cascade to their managers, which defines the process for storage of such information i.e, shared files, use of personal 'P' drives, password protected, accessibility etc. Develop examples of good practice and checklist examples for cascade through Divisions and use in training events.	Cath O'Brien, Chief Operating Officer	Judy Stafford, People and Relationships Manager Judy Stafford, People and Relationships Manager	30th November 2022 Extension Agreed April 2023 Audit Committee: 31 August 2023 31st December 2022 Extension Agreed April 2023 Audit Committee: 31 August 2023	Complete	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.		Complete: Updating is completed on the roll out of the e-filing project each time.		9 Months 8 Months
	3.2 Pursue the rollout of centralised personnel folders for VCC, in line with the solution implemented within WBS.	Medium	Finalise the business requirement case for centralised workforce folders at VCC (in line with WBS) and implement the system.	Cath O'Brien, Chief Operating Officer	Rachel Hennessy/Paul Wilkins, Director of VCC and Alan Prosser Director of WBS	31st July 2023	On Target	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	The roll out of e-files has been completed for the following departments - Therapies, Ambulatory Care, 1st Floor ward, IV Access Team, and Theatres. Dates are set up for the next couple of weeks to roll out to other Nursing departments - Assessment Unit, Palliative Care, Q&S team, CNS Team and Nursing Admin. These will all be rolled out by end of May. Next departments are in phase 1 of roll out (prepping) - OPD, Medical Records, Private Patients, Clinical Audit, Pharmacy and Nuclear Medicine.	The roll out is progressing well and further departments have been completed - Psychology (including Clinical Psychology, Supportive Care, Complementary Therapy, Welfare Rights, WIBSS), and Quality and Safety Teams. The plan requires regular amending due to lack of capcity of department managers etc. Next department which have been prepped and set up are Pharmacy and SACT, Palliative Care, Nursing Admin, and Clinical Audit which will be completed in the next couple of weeks.		
	3.3 Implement the planned programme of audits to ensure continued adherence to the MAAW Policy and update EMB on the status of this programme.	Medium	A rolling programme of audits was agreed in September 2021 by EMB; this was impacted by COVID and replaced by spot audits in hotspot areas due to service pressures. The rolling programme agreed is now back on track and is ongoing with targeted dates on updates to EMB in December 2022 and March 2023.	Cath O'Brien, Chief Operating Officer	n/a	n/a	Action Closed	n/a	n/a	n/a	n/a	n/a

Audit Action Plan

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Medium	< 1 month *

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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 March / April 2023	Update May 2023	Update June 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,~~ Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023 Extendion Request Agreed April 2023 Audit Committee: 30 May 2023	On Target	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 absense.		Under development.		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 Refrences to include oversight of patient / donor CIVICA feedback (including volume feedback, outcomes, improvement actions and ongoing trend and theme monitoring and the utilisation of feedback to inform prioritisation and decision making at all levels.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Divisional Director WBS & VCC Alan Prosser, Director of WBS & Rachel Hennessy/Paul Wilkins Director of VCC	31/03/2023	Action Closed	**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 readniess for their monthly meetings. From 1st April 2023 there will be a full time Patient Experience and Concerns Manager in post who will work closelywith 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 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.	n/a	n/a	n/a	n/a
	1.1c ensure relevant staff are clear on the above, e.g., though publicising the new quality and safety governance and reporting mechanisms at team meetings on the intranet.	Medium	See 1.1 a	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	~~Nigel Downes,~~ Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023 Extendion Request Agreed April 2023 Audit Committee: 30 May 2023	On Target	See update relating to 1.1a above.		Dependent on action above being completed.		2 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	Action Closed	**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 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.	n/a	n/a	n/a	n/a
	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	Overdue	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.	Civica have confirmed their work on this will be completed by 19/05/2023. Emma Powell Has asked The BI Team to work on this once the link is established. Nicola Williams is agreeing measures. Need development time to build the ETL to bring the data in, the measures require from that data and then testing and UAT so extension is requested until end July 2023.		21-Jul-23	3 Months
	2.1b. Ensure that reports contain succinct, concise executive summaries that clearly highlight key messages.	Medium	b. As outlined in 2.1.a	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	Emma Powell, Head of Information	30/04/2023	Action Closed	**Complete.** See update for 2.1a	n/a	n/a	n/a	n/a
Matters Arising 3	**Feedback to Staff** 3.1 The Trust should incorporate how it effectively communicates patient and donor experience feedback to all staff as part of its review of quality and safety governance and reporting mechanisms.	Medium	The patient / Donor experience feedback procedure (detailed under 1.1a) to include expectations of how feedback should be communicated to staff at all levels and how staff are involved in the 'so what' analysis.	Nicola Williams, Director of Nursing, AHP's & Medical Scientists	~~Nigel Downes,~~ Tina Jenkins, Deputy Director Nursing, Quality & Patient Experience	31/03/2023 Extension Request Agreed April 2023 Audit Committee: 30 May 2023	On Target	See update relating to 1.1a above.		Dependent on action above being completed.		2 Months

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Velindre UNHS Trust

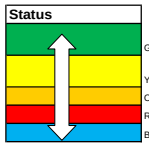
New Velindre Cancer Centre Development: Contract Management					Assurance Rating: Limited			Date Received at Audit Committee: 12 January 2023				

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update February 2023	Update March / April 2023	Update May 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	Action Closed		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 Baord 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	Action Closed		A Scheme of delegation for major capital projects has been developed which was presented to EMB Shape on 20.03.23 and endorsd for review by the Audit Committee at the 23.04.23 meeting for Board aproval 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	Complete			Action closed - approach agreed with Ims in March round of approvals		

Audit Action Plan

Velindre UNHS Trust

Status



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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 February 2023	Update March / April 2023	Update May 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			Action Closed					
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			Action Closed					
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			Action Closed					

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Velindre UNHSTrust

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 March / April 2023	Update May 2023	Update June 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 Extension Request Agreed April 2023 Audit Committee: 30 April 2023	Overdue	5 new improvement goals iweaved into sections of IMTP aligned with safe care collaborative priorities. Being explicitly pulled out to add to Quality sections.	Four of five priorities agreed, aligned with Safe Care Collaborative Priorities. Measurable outcomes are beng determined.	Four of five priorities agreed, aligned with Safe Care Collaborative Priorities. Measurable outcomes are being determined.		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	Action Closed	**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..	n/a	n/a	n/a	n/a
R2	b) Scrutinise progress to address gaps in controls and assurances.	N/A	b. Further scrutiny and evidence of this, in line with the comments made in the report, will be actioned as part of the next governance cycle review of the Trust Assurance Framework	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	January 2023	Action Closed	**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..	n/a	n/a	n/a	n/a
R3	Risk registers presented to meetings do not always include enough information to allow good scrutiny. The Trust should: a) Determine what information is needed in risk registers (including the Corporate Risk Register) to enable good scrutiny and challenge (such as including opening, current and target risk scores, and sufficient clarity on existing controls and mitigating action).	N/A	a) Quality of data and consistency of reporting is a focus of the current risk work. (Cross-reference to Governance, Assurance and Risk work under BOFT - Project Risk 4.0 & Risk 5.0)	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	March 2023	Action Closed	**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..	n/a	n/a	n/a	n/a
R3	b) If risks appearing in the Trust Risk Register have been discussed in other agenda items, provide suitable cross references in the cover report.	N/A	b) To be included in new Cover Paper Template and Risk Register report (Cross-reference to Governance, Assurance and Risk work under BOFT - Project GOV 2.0).	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	January 2023	Action Closed	**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.	n/a	n/a	n/a	n/a
R3	c) Executive risk owners should lead discussions on risks within their areas of responsibility.	N/A	c) Implement from next governance cycle.	Lauren Fear, Director Corporate Governance and Chief of Staff	Lauren Fear, Director Corporate Governance and Chief of Staff	January 2023	Action Closed	**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.	n/a	n/a	n/a	n/a

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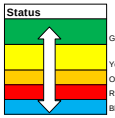
External Audit Report - Review of Quality Governance Arrangements - VUNHST					Assurance Rating: N/A			Date Received at Audit Committee: 12 January 2023				
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update March / April 2023	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
R4	a) Progress to develop a Trust-wide action plan to address findings from the NHS Staff Survey slowed due to the impact of the pandemic. The Trust should progress work to develop the action plan as soon as possible and: a) Undertake work to understand why some staff feel that the Trust does not take effective action to deal with bullying, harassment or abuse.	N/A	a) Trust-wide conversations are underway regarding the way staff feel about working in the organisation. The outputs of this work will give a picture of the culture of the organisation and enable the next iteration of the Trust Values. Part of this engagement work will also be extended to address particular feedback on dealing with bullying, harassment or abuse.	Sarah Morley, Executive Director of Organisational Development and Workforce	Sarah Morley, Executive Director of Organisational Development and Workforce	January 2023	Action Closed	n/a	n/a	n/a	n/a	n/a
R4	b) Undertake work to understand why some staff may feel that the Trust does not act adequately to address concerns.	N/A	b) The work described at a) will also address the issue of dealing with concerns raised in the workplace.	Sarah Morley, Executive Director of Organisational Development and Workforce	Sarah Morley, Executive Director of Organisational Development and Workforce	January 2023	Action Closed	n/a	n/a	n/a	n/a	n/a
R5	Some of the attendees of meetings that consider quality and safety matters in VCC felt that there is duplication of coverage, and that not all meetings had appropriate representation. When operationalising the Quality Hubs, the Trust should for VCC and WBS and Trust-wide. a) Ensure that the group structures and meeting remits avoid unnecessary duplication of coverage. b) Ensure that attendees of each meeting are appropriate and provide adequate representation of relevant disciplines. c) Ensure that the Trust has clearly articulated which meetings consider quality and safety matters and their reporting lines.	N/A	Integrated Quality and Safety Group to be established (19th October 2022). The Group will take responsibility for reviewing Trust-wide quality and safety related meeting structures, including required representation. Output to be approved by Executive Management Board and the Quality, Safety and Performance Committee. It is noted however, that this will require ongoing review as the Trust and Integrated Quality and Safety Group matures.	Lauren Fear, Director Corporate Governance and Chief of Staff and Nicola Williams, Executive Director Nursing, AHP and Health Science.	• Nicola Williams, Executive Director Nursing, AHP and Health Science; • Lauren Fear, Director Corporate Governance & Chief of Staff; • Emma Stephens, Head of Corporate Governance	March 2023	Action Closed	**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 3 months.	n/a	n/a	n/a	n/a
R6	Information in reports and performance data are sometimes out of date. The Trust should ensure that as far as possible, data and information presented to the Quality, Safety and Performance Committee meeting is as up to date as possible, covering agreed time periods.	N/A	Reporting cover periods to be made explicit as part of Committee agenda setting and work plan.	Lauren Fear, Director Corporate Governance and Chief of Staff and Nicola Williams, Executive Director Nursing, AHP and Health Science.	• Nicola Williams, Executive Director Nursing, AHP and Health Science; • Lauren Fear, Director Corporate Governance & Chief of Staff; • Emma Stephens, Head of Corporate Governance	From January 2023 Quality, Safety and Performance Committee	Action Closed	**Complete.** QSP Cycle of Business amended and reporting periods realigned.	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

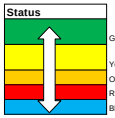
Velindre UNHS Trust

External Audit Report - Structured Assessment 2022 - Velindre University NHS Trust | **Assurance Rating: N/A** | **Date Received at Audit Committee: 25 April 2023**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
Recommendation 1	**Improving administrateive governance arrangements** We found that opportunities remian for the Trust to improve the public availability of key papers and documents on its website. This includes publishing: - missing committee meeting papers. - the Register for Gifts, Hospitality and Sponsorship and the Declaration of Interest Register; and	High	Tracking has been implemented to ensure the completeness and timely publication of committee agenda bundles and other key governance papers as part of the weekly Corporate Governance Team meeting.	Lauren Fear - Director of Corporate Governance and Chief of Staff	Kay Barrow, Corporate Governance Manager	22nd March 2023	Complete	This is now a standing item at the Corporate Governance Weekly Team meeting.	n/a	n/a	n/a
Recommendation 1	- the ten year strategy and enabling strategies. The Trust should establish a clear and robust process to ensure it publishes key papers and documents on its website in a timely and ongoing basis	High	10-year strategy: An engagement andcommunications plan has beendeveloped to the support the launch ofthe Trust 10-year strategy in May 2023. This will include publishing the strategy on the Trust website	Lauren Fear - Director of Corporate Governance and Chief of Staff	Carl James - Executive Director of Strategic Transformation, Planning and Digita	31st May, 2023	On Target				
Recommendation 2	**Reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies** The Quality, Safety, Performance Committee has not received the log which tracks recommendations relating to the quality and safety of services made by external inspection and regulatory bodies since early in 2020. The Trust should immediately reinstate the tracker to enable the committee to oversee, scrutinise, and challenge the progress it is making in addressing both quality and safety recommendations and any relating to performance	High	The Quality & Safety Extract of the Trust Wide Legislative & Regulatory Compliance Register will be received at each meeting of the QSP Committee - together with the associated Improvement Plan using the 7 levels of assurance template. Note: The Trust wide Legislation & Regulatory Compliance Register is already established and received in full by the Trust Audit Committee.	Nicola Williams Executive Director of Nursing, AHP & Health Science	Zoe Gibson, Head of Quality & Safety and Emma Stephens, Head of Corporate Governance	Mar-23	Complete	Paper going to May 2023 Committee and regular exception reporting planned thereafter.	n/a	n/a	n/a
Recommendation 3	**Establishing measurable outcomes for strategic priorities** The Trust has translated its strategic priorities into specific objectives and actions in the 2022-25 IMTP (including timescales for delivery). The Trust should seek to articulate the intended outcomes for each strategic objective/action in future IMTPs, including what success would look like	High	The Trust IMTP 2023-2026 sets out a range of specific objectives related to their delivery which are timebound. Further work will be undertaken to: (i) improve the SMART elements of the objectives (ii) align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase 2)	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	30th March, 2023	Complete	The IMTP 2023 - 2026 was developed in a SMART methodology for key objectives. Each priority was also mapped to a the primary outcome/output and aligned with the key performance indicator; Action complete.	n/a	n/a	n/a
		High	(ii) align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase 2)	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Dec-23	Complete	The alignment of indicators has been undertaken within Phase 1 of the PMF work. Action closed	n/a	n/a	n/a
Recommendation 4	**Enhancing reporting on 2022-25 IMTP Delivery** The Trust's arrangements for reporting delivery of the 2022-25 IMTP are reasonable, but it needs to better describe the impact the actions are making. The Trust should report on the impact of actions delivered to date to allow the Board to better understand the extent that delivery of the IMTP is making a difference and determine any actions that need to be rolled forward to the 2023-26 IMTP	High	The Trust IMTP for 2023-2026 will outline the impact/benefits of actions we are taking as outlined in our IMTP. The process for developing the IMTP has included an assessment of actions which should be rolled forward to 2023-2026. In respect of reporting, we will ensure that progress update are provided to: - Senior Leadership Team at their monthly meetings - Executive Management Board at their monthly meetings - Quality, Safety and Performance Committee at their bi-monthly meetings - Trust Board at their bi-monthly meetings	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	31st May 2023	Complete		The Trust Board and its committees receive reports which sets out impacts together with a range of other information. Work has been undertaken to strengthen the relationship between the IMTP actions and their tangible impacts at a service level - including completion of Phase 1 of the performance management framework; strengthening of the Risk Register; development of the Trust Risk Assurance Framework; and introduction of the 7 levels of assurance. Closed		

Audit Action Plan

Status



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Red - Implementation date passed - Action not complete

Blue - Action closed previous meeting

Priority

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

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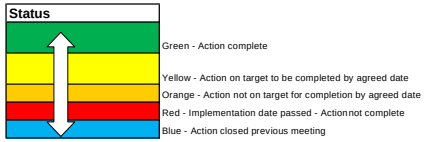
Velindre UNHS Trust

External Audit Report - Structured Assessment 2022 - Velindre University NHS Trust					Assurance Rating: N/A			Date Received at Audit Committee: 25 April 2023			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
Recommendation 5	**Improving reporting on the benefits arising from digital investments** Whilst there is good reporting on progress in delivering key digital projects and programmes, the reports do not provide an assessments of what difference they are making, whether they are sufficiently recourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.	High	The further development of digital benefits will be undertaken in several ways: (i) a range of key performance indicators that are reported to the Executive Management Board	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	31st May 2023	Overdue	The Performance Management Framework includes the agreed current Digital measures. QSP have agreed which measures are to be brought forward to Board committee level (Cyber Security compliance and IT Business Continuity). The QSP Digital Report (presented in May '23 had its format changed to show the intended benefits for each of the digital activities). We will continue to develop this format for future reports.	Initial set of digital measures have been implemented into the performance management framework to EMB in May/June 2023		
Recommendation 5			(ii) improving the clarity of benefits in projects/business cases on a case-by-case basis	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Not time bound - as related to each business case	Complete	Ongoing. No new business cases have been presented to date.	The FBC for new Velindre Cancer Centre, Digital Health and Care Record and WHAIS all included clear benefits. This is an ongoing BAU activity. Closed		
Recommendation 5			(iii) implementing the measures set out within the digital strategy and key service plans (e.g., quality metrics) which will demonstrate the impact of digital services on service quality and outcomes and including an overall % spent on digital technology	Carl James Executive Director of Strategic Transformation, Planning and Digital	Carl James Executive Director of Strategic Transformation, Planning and Digital	Feb-24	On Target	We are expecting the Digital Strategy to be published in June '23. We will then start to introduce these measures in phases through the Performance Management Framework which will then be in place by the Feb '24 deadline.	Initial set of digital measures have been implemented into the performance management framework to EMB in May/June 2023		

Audit Action Plan



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

Clinical Audit (Velindre Cancer Centre) Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 25 April 2023			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
Matters Arising 1	**Matter Arising 1: Clinical Audit Actions** 1.1 a. The clinical audit action plan should be updated in a timely manner. We understand the implementation of AMaT will support this, as the Clinical Leads will be responsible for inputting and updating action plans.	Medium	1.1a The Clinical Audit Team is currently piloting AMaT with the anticipation to roll the system out across all audits in the team. A review of audit systems in the organisation is being undertaken to ensure no duplication of systems and explore how AMaT can support other areas of the Trust.	Jacinta Abraham, Medical Director	Nicola Hughes, Medical Directorate Manager	Jun-23	Complete	Amat has been agreed at SLT. Audit team in the process of uploading active and completed audits and forming an implementation plan .	New audits are being registered on AMaT. A plan to launch AMaT to be presented to different VCC forums within the next month. AMaT is now the official audit tool for capturing clinical audits within the organisation.		
Matters Arising 1	1.1 b. Where clinical audits lead to clear actions, Clinical Leads should ensure actions noted within the clinical audit action plan are SMART. The use of AMaT will provide the foundation for standardisation and should assist with creating SMART actions. The Clinical Audit Team should undertake spot checks on the actions to verify this.	Medium	1.1b Once the SMART action guide (see 1.1c below) has been produced, the Clinical Audit Team will undertake spot checks on actions to ensure they are SMART.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Apr-23	Complete	Once document complete spot checks will take place. We are currently reviewing current action plans.	SMART action plan tool has been developed. This will be uploaded onto the intranet and will be provided when an action plan needs to be developed to support the audit. Once action plans are developed the audit team will undertake spot checks to ensure the actions are SMART.		
Matters Arising 1	1.1 c. Guidance and training on developing SMART actions should be provided to Clinical Leads.	Medium	1.1c Produce a SMART action training guide for all audit leads to follow.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Apr-23	Complete	Document in progress.	SMART action plan tool has been developed. This will be uploaded onto the intranet and will be a tool provided when an action plan needs to be developed to support the audit. Once action plans are developed the audit team will undertake spot checks to ensure the actions are SMART.		
Matters Arising 1	1.2 a. The clinical audit action plan should identify whether a re-audit is required, along with the reason and timescales therefor.	Medium	1.2a Where re-audit is required, this is included in the action plan, a section will be added to document the reason for re-audit. Timescales are usually recorded. Not all audits require re-audit this is identified via the recommendation or documented on the proforma. Ensure where re-audits are required that all documentation reflects this clearly.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Mar-23	Complete	Documentation has been updated to reflect re-audit requirements. Once AMaT fully implemented this will be added to the action plans with a re-audit date.	n/a	n/a	n/a
Matters Arising 1	1.2 b. The Trust should develop a process for independently verifying implementation of actions and benefits realisation where re-audit is not planned. This could be undertaken on a spot-check / sample basis and could be done by the Clinical Audit Team or, to create resilience, by a clinician who was not involved in the original audit.	Medium	1.2b Formalise the current process to evidence actions and benefits have been undertaken or realised.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jun-23	Complete	Currently adding completed audits to AMaT so that actions can be monitored.	AMaT will allow the audit team to review actions after an audit has been completed. As part of the audit sign off process within AMaT, the Audit Manager has to officially sign off each project There is a functionality called "post project impact", which will facilitate the review of the imact of the actions. With using AMAT as the audit tool this allows the audit team to ensure benefits from the actions have been realised as part of the sign off process of the audit. AMaT		
Matters Arising 2	**Matter Arising 2: Clinical Audit Best Practice** 2.1 The Trust should consider the above points and the wider HQIP clinical audit best practice guidance as it continues to develop its clinical audit activities, and reviews quality governance mechanisms as part of the Quality & Safety Framework Implementation Plan.	Low	2.1 All best practice identified in this report to be reviewed and applied where possible to improve the effectiveness of clinical audits.	Jacinta Abraham, Medical Director	Catherine Pembroke, Medical Clinical Audit Lead (Oncology Consultant)	Jul-23	On Target	In progress.	The Quality Improvement (QI)Hub will focus on overseeing, mentoring and implementing sustained change. Audit outcomes will be actioned and disseminated to clinical groups. The QI Hub will feed into the Trust Quality Hub		
Matters Arising 3	**Matter Arising 3: Centralised Clinical Audit Function** 3.1 The Trust should consider joining the divisional clinical audit teams into a centralised Trust clinical audit team.	Low	3.1 Discuss the options regarding feasibility of a centralised clinical audit team or exploring how WBS and VCC can work together ensuring processes are aligned across the organisation.	Jacinta Abraham, Medical Director	Jacinta Abraham, Medical Director	Jul-23	On Target		Discussions have taken place with the Medical director and divional leads for WBS and VCC to determine the best approach to clinical audit wihin the Trust. Currently scoping the benefits of the current structure and how the two divisions can work together to support clinical audit. function		

Audit Action Plan

Velindre UNHS Trust

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

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

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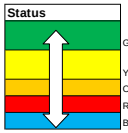
Clinical Audit (Velindre Cancer Centre) Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 25 April 2023			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
Matters Arising 4	**Matter Arising 4: Robustness of SST Minutes** 4.1 The Trust should ensure that SST meeting minutes clearly demonstrate discussions around clinical audit (plan progress, audit findings, learning, action implementation, etc).	Medium	4.1 Annual audit engagement with each SST with robust documented discussion including annual plan, progress, learning and actions.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jul-23	Complete	Discssed at SST leads meeting agreed to meet with leads, medical clinical audit lead, Medical Directorate Manager. Meetings due to commence Jul/Aug.	This has been impletemented as part of the annual audit plan cycle to support the develop of the annual audit plan.		
Matters Arising 4		Medium	4.1 Review of SST meetings to establish how discussions are documented with progress of clinical audits	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Jul-23	Complete	In progress - new SST administrator in post.	Review of the SST's are being undertaken and ToR being reviewed. Audit will be a standard agenda item on the SST meetings and will be recorded in the minutes.		
Matters Arising 5	**Matter Arising 5: Clinical Audit Reporting and Oversight Mechanisms** 5.1a As part of the review of quality and safety governance and reporting mechanisms, the Trust should address the above points to further enhance the efficiency and effectiveness of the scrutiny and oversight of clinical audit activities from 'floor to Board'.	Low	5.1a The new Trust Integrated Quality and Safety Governance group will help with the triangulation of clinical audit outcomes across the Trust and ensure escalation to the Quality and Safety committee as appropriate. VCC will develop a process map to evidence the report structures within VCC for clinical audit. Reporting requirements are being reviewed in line with the quality hubs.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	Dec-23	On Target	VCC quality hub being developed.	VCC quality improvment hub being developed.		
Matters Arising 5	5.1 b The Trust should ensure that the agreed clinical audit reporting mechanisms are clearly communicated to relevant staff and adhered to at all levels of the Trust.	Low	5.1b **VCC**: Current process map of the VCC governance and reporting mechanism to be added to the clinical audit intranet page.	Jacinta Abraham, Medical Director	Sara Walters, Clinical Audit Manager	May 2023	On Target	Will be developed once VCC quality hub has been fully established	Governance and reporting process mapp is in the process of being developed and will be added to the intranet however, this will change when the quailty hub has been fully implemented.		1 month
		Low	5.1b **WBS:** We have strengthened the reporting of Clinical Audit within the WBS by making it an integral part of the Welsh Blood Service Clinical Governance Groups, reporting to the Regulatory Assurance and Governance Group (RAGG). We have recently added a separate report including national comparative audits.	Jacinta Abraham, Medical Director	Edwin Massey, Deputy Medical Director WBS	Completed	Complete	Action marked as completed on report that went to April 2023 Audit Committee.	n/a	n/a	n/a

Audit Action Plan



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

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Velindre UNHS Trust

Information Governance Final Internal Audit Report					Assurance Rating: Reasonable			Date Received at Audit Committee: 25 April 2023			
Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
Matters Arising 1	**Matter Arising 1: Areas for Improvement Already Identified (Design)** 1.1 Consider whether: • the above identified areas for improvement should also be incorporated into the Audit Committee's Audit Action Tracker; or • the Audit Committee should receive an annual IG update covering progress against the IG workplan until all key actions are sufficiently implemented.	Medium	1.1 The Trust will provide updates to the Audit Committee on annual basis covering progress against the IG Workplan until all key actions are sufficiently implemented. This will ensure that Assurance in relation to progress is received quarterly by the Board via EMB and QSP Committee.	Matthew Bunce, Executive Director of Finance	Ian Bevan, Head of Information Governance	30th June 2023	On Target	Latest workplan progression reported to EMB on 2nd May 2023, report available for perusal by QSP on 16th May 2023 should they require it. On track to report from 30th June onwards as the new IG Toolkit will have been completed by that date which will inform the IG workplan for 2023-24.	Offline version of IG Toolkit 75% complete. The work is saving evidence in the relevant folder, uploading is a quicker task. Deadline remains 30th June 2023 which remains achievable.		
Matters Arising 1	1.2 Include the development of the Records Management Strategy and SOP in the IG development plan.	Medium	1.2 The Trust has already included the development of the Records Management Strategy and SOP in the IG Development Plan, the latest report of which will be presented to the Integrated Quality and Safety Group on 14th March 2023.	Matthew Bunce, Executive Director of Finance	Ian Bevan, Head of Information Governance	Achieved	Complete	Noted as achieved on the report taken to the April 2023 Audit Committee.	n/a	n/a	n/a
Matters Arising 2	**Matter Arising 2: IG resource level (Design)** 2.1 Consider whether there is sufficient resources within the IG function to support its ongoing development and compliance with legislation.	Medium	2.1 The Trust will consider the subject of sufficient resources for the IG Function to support ongoing development and compliance with legislation. Due to the need to properly identify resources, the identified timeline takes account of need to conduct the assessment properly.	Matthew Bunce, Executive Director of Finance	Matthew Bunce, Executive Director of Finance (Senior Information Risk Owner (SIRO))	30th June 2023	On Target	For discussion between HOIG/SIRO - on track for delivery on 30th June 2023	HOIG focus is to assist recruitment of new FOIA Officer. This will free up resources to enable HOIG to focus on core elements of the tasksing. HOIG/SIRO will continue to discuss resources with aim of identfying those tha could support the IG function in 2023/24.		
Matters Arising 3	**Matter Arising 3: Mandatory IG Training uptake (Operation)** 3,1 Remind staff within the areas below the IG training compliance target: • to keep their mandatory IG training up to date; and • why it is important to do so. This could be achieved through corporate communications and line management structures.	Medium	3.1 The Trust has already addressed this recommendation via line management structures in an email to all Trust Directors on 3rd March 2023. In that email, the following communication was issued: *"The Trust has received a copy of the draft IG Internal Audit report, and whilst our Trust compliance figures are 85.98% as of 28th Feb 23, as you can see below, the divisional compliance data however is slightly different". (A copy of the compliance table was issued to Directors)* *"The minimal compliance figure is 75%3 (which is what the Audit report identified as the minimal baseline as well). To increase compliance levels, may I request that your teams complete their mandatory training on ESR. However, to try and assist, I am available for sessions to enable our Staff to complete their training in a face to face format if this is a better and easier approach, this can be bespoke or by joining pre-existing team meetings. There will of course be a competency check at the end of the session (pass mark 16/20) so that the Trust can be assured the training is delivering what it needs to in terms of ensuring our Staff have been trained properly".*	Matthew Bunce, Executive Director of Finance	Ian Bevan, Head of Information Governance	Achieved	Complete	Noted as achieved on the report taken to the April 2023 Audit Committee.	n/a	n/a	n/a

Audit ActionPlan

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

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Velindre UNHS Trust

Capital Systems Final Internal Audit Report | **Assurance Rating: Reasonable** | **Date Received at Audit Committee: 25 April 2023**

Ref	Recommendation	Priority	Management Response	Executive/Director Lead	Responsible Manager/Officer Lead Department where lead works	Agreed Implementation Date	Status	Update May 2023	Update June 2023	Requested Extension Date	Extension (Months)
Matters Arising 1	**Matter Airising 1: Governance - Capital Procedures (Operation)** 1.1 FP01 Capital Management Procedure should be reviewed and updated.	Low	1.1 Accepted: The Capital Management Procedure will be updated and will be submitted for approval following Trust governance requirements.	Carl James, Director of Strategic Transformtion, Planning & Digital / Matthew Bunce, Executive Director of Finance	Steve Colliandris, Head of Financial Planning & Reporting	30 November 2023	On Target	On course to be completed by the agreed implementation date.	On course to be completed by the agreed implementation date. Capital Management procedure will be going to the Capital planning Group on the 28th June for Endorsement before following the formal governance route for approval.		
Matters Arising 2	**Matter Arising 2: Governance - Dicisional Structure Operation)**The 2.1 VCC capital governance structure should be reviewed, and either: a) The Business Planning Group re-instigated as per the terms of reference; or b) A revised structure implemented, to ensure an appropriate forum is in place for the monitoring of capital requirements and reporting to the Senior Leadership Team.	Medium	2.1 Accepted: The VCC Business Planning Group will be re-instigated in line with the approved Term of Reference.	Carl James, Director of Strategic Transformtion, Planning & Digital	Paul Wilkins, Director of Cancer Services, Velindre Cancer Centre	30 June 2023	On Target				
Matters Arising 3	**Matter Arising 3: Governance - Capital Planning Group (Operation)** 3.1 Capital Planning Group (or other equivalent forum) minutes should: • Be prepared in a timely manner after each meeting, and in readiness for sign-off at the subsequent meeting; • Clearly document any decisions taken (for example in relation to formulation of the annual discretionary programme); and • Be centrally retained in a location accessible by key forum members, including as a minimum the Chair and Deputy Chair. It is noted that a number of organisations now utilise Microsoft Teams to facilitate meeting administration, with a dedicated Teams channel being a useful central location for retention of key meeting documentation.	Medium	3.1 Accepted: The following actions will be taken: • Minutes will be made available no later than two weeks after each meeting for review by the Chair of the Group • All key decisions taken will be clearly documented • A shared folder will be established and all members of the Capital Planning Group will have access to minutes and other associated papers	Carl James, Director of Strategic Transformtion, Planning & Digital	Philip Hodson, Deputy Director of Planning & Performance	30 June 2023	Complete	Minutes – Action Closed: Following this audit recommendation minutes from the Capital Planning Group will be published within two weeks of each meeting. Key decisions – Action Closed: Following this audit it has been agreed that all key decisions will be included within the meeting minutes. In addition a audio recording of the meeting will be retained. Shared folder – Action Open: It has been agreed that there will be a shared folder which all access of the Capital Planning Group can access. This will be actioned in line with the agreed deadline of 30th June 2023.	Minutes – Action Closed: Following this audit recommendation minutes from the Capital Planning Group will be published within two weeks of each meeting. Key decisions – Action Closed: Following this audit it has been agreed that all key decisions will be included within the meeting minutes. In addition a audio recording of the meeting will be retained. Shared folder – Action Open: It has been agreed that there will be a shared folder which all access of the Capital Planning Group can access. This will be actioned in line with the agreed deadline of 30th June 2023.		
Matters Arising 4	**Matter Arising 4: Governance - Capital Delivery Group Terms of Reference (Operation)** 4.1 The terms of reference for the Capital Delivery Group should be approved in a timely manner, in line with the wider change timeline.	Low	4.1 Accepted: The revised terms of reference will be submitted for approval through Trust agreed governance arrangements.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital	30 June 2023	On Target				
Matters Arising 5	**Matter Arising 5: Prioritisation Framework - Consistency of application (Operation)** 5.1 Clarification is required within the Capital Prioritisation Framework as to whether there are any exceptions to the requirement to complete the Capital Prioritisation Information Template (including in the management of "discretionary" funds).	Low	5.1 Accepted: The Capital Prioritisation Framework will be reviewed and updated in line with the recommendation.	Carl James, Director of Strategic Transformtion, Planning & Digital	Deputy Director of Planning & Performance	30 June 2023	Complete	Application of the Capital Prioritisation Framework – Action Open: A revised draft of the Capital Prioritisation Framework has been developed and has been issued for comment. The revised Framework will be completed and issued in line with the agreed deadline of 30th June 2023.	Application of the Capital Prioritisation Framework – Action Closed: The Capital Prioritisation Framework has been reviewed and confirmation has been provided to members of the Capital Planning Group that this must be completed and approved for all discretionary capital schemes.		
Matters Arising 6	**Matter Arising 6: Prioritisation Framework - Annual Approval Timeline (Operation)** 6.1 The discretionary capital programme should be formulated and agreed prior to the start of the financial year wherever possible. The planning cycle in the Divisions should be aligned to support this.	Medium	6.1 Accepted: Where possible the capital programme will be approved prior to the start of the financial year. However, it should be noted that this is not always possible due to uncertainty regarding our discretionary capital allocation from WG and / or our contribution to centrally funded schemes e.g. delay in approval of All-Wales business cases e.g. nVCC.	Carl James, Director of Strategic Transformtion, Planning & Digital	Carl James, Director of Strategic Transformation, Planning & Digital With support from VCC and WBS.	31 March 2024 and ongoing thereafter	On Target	Will be picked up within the IMTP 2024/2025 process	The IMTP planning process will be amended to enable the discretionary capital programme to be agreed before the commencecment of each financial year. The process has commenced for 2024/2025 and is on-track		

AUDIT COMMITTEE

2022/23 HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT

DATE OF MEETING	26th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Emma Rees, Deputy Head of Internal Audit
PRESENTED BY	Simon Cookson, Director of Audit & Assurance Services
APPROVED BY	Simon Cookson, Director of Audit & Assurance Matthew Bunce, Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to present the 2022/23 Head of Internal Audit Opinion and Annual Report (the Opinion).
RECOMMENDATION / ACTIONS	The Audit Committee is invited to **NOTE** the content of the 2022/23 Opinion.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Board Development Session	18/04/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The draft 2022/23 Opinion was considered as part of the Board's discussions on the 2022/23 annual Governance & Accountability Assessment / Trust Board Effectiveness, which forms part of the Governance Statement within the Accountability Report.

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Not applicable for Head of Internal Audit Opinion For 2023/24 onward, the 7 levels of assurance for individual internal audit reports will be detailed in individual covers papers where applicable.

APPENDICES (included within Opinion document)	
Appendix A	Conformance with Internal Audit Standards
Appendix B	Audit Assurance Ratings

1. SITUATION

In accordance with the Public Sector Internal Audit Standards, we (NWSSP Audit & Assurance Services) present the 2022/23 Head of Internal Audit Opinion & Annual Report (the Opinion) to support the development of the Trust's Annual Governance Statement.

2. BACKGROUND

The Audit Committee is invited to **NOTE** the content of the 2022/23 Head of Internal Audit Opinion & Annual Report.

3. ASSESSMENT

The 2022/23 Opinion provides the Board with **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

In developing the Opinion, we have considered:

- 17 completed reviews undertaken as part of the Trust's Annual Internal Audit Plan (14 assurance reviews and three advisory reviews); and
- ten reviews undertaken at NHS Wales Shared Services Partnership (four assurance reports and one advisory review report) and Digital Health and Care Wales (five assurance reports).

We also considered the status of the nVCC and Enabling Works Integrated Audit & Assurance Plans. Five 2022/23 nVCC IAAP elements were deferred to 2023/24 (in alignment with nVCC project progress) and reporting was paused on our 2022/23 Enabling Works audit to consider and reflect on changes to critical nVCC project timelines.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
NO From 2023/24 onward, Internal Audit reports will be linked to the strategic goals in the cover paper for each individual report, where applicable.	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	☐ ☐ ☐ ☐ ☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	10 - Governance Internal Audit reports are linked to the TAF in the Annual Internal Audit Plan. From 2023/24 onward, they will also

For more information: STRATEGIC RISK DESCRIPTIONS	be linked in the cover paper for each individual report, where applicable.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	Individual Internal Audit reports may provide assurance over the Quality Domains and Enablers. Internal Audit reports are linked to the Quality Domains and Enablers in the individual audit briefs. From 2023/24 onward, this will also be done in the cover paper for each individual report, where applicable.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Annual Head of Internal Audit Opinion

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	Individual Internal Audit reports may provide assurance over the Wellbeing Goals.
	For 2023/24 onwards, Internal Audit reports will be linked to the Wellbeing Goals in the cover paper for each individual report, where applicable.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required

For more information: *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required for Annual Head of Internal Audit Opinion
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Legal risks identified in our audits will be highlighted in the cover report for each individual report, where applicable.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Internal Audits are linked to the Trust Risk Register in the Annual Internal Audit Plan. From 2023/24 onward, we will include this link in the cover paper for each individual report.
WHAT IS THE CURRENT RISK SCORE	N/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/a
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/a
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	N/a
All risks must be evidenced and consistent with those recorded in Datix	

Head of Internal Audit Opinion & Annual Report 2022/23

July 2023

Velindre University NHS Trust

Contents

Report status: Final
Draft report issued: 11th April 2023
Final report issued: 19th July 2023
Author: Emma Rees, Deputy Head of Internal Audit
Executive Clearance: Lauren Fear, Director of Corporate Governance & Chief of Staff
Matthew Bunce, Director of Finance
Audit Committee: July 2023

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Velindre University NHS Trust's (the Trust) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2022-23

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2022/23 is that:

Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

The Internal Audit Plan for 2022/23 year was presented to the Committee in May 2022. Changes to the plan have been made during the year and these changes have been reported to the Audit Committee as part of our regular progress reporting. We confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

There are, as in previous years, audits undertaken at NWSSP and DHCW that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy in 2023, and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2022/23.

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have identified high priority matters arising, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

A summary of the audits undertaken in the year and the results are summarised in table 1.

Table 1 – Summary of Audits 2022/23

Substantial Assurance	Reasonable Assurance
• Digital Health Record – Implementation • Research & Development • Cyber Security	• Trust Priorities • Capital Systems • Clinical Audit • Managing Attendance at Work • Finance & Service Sustainability • Information Governance • nVCC Enabling Works (deferred from 2021/22) • Patient & Donor Experience • Performance Management Framework • Follow Up of Prior Year Recommendations
Limited Assurance	**Advisory/Non-Opinion**
• nVCC MIM Contract Management	• Staff Wellbeing • nVCC Enabling Works Security Contract • Decarbonisation
No Assurance	
N/A	

Please note that our overall opinion has also considered the number and significance of any audits that have been deferred during the year (see section 5.7) and other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Trust's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Trust. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Velindre University NHS Trust which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2021/22 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were used to frame the audit planning at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance

The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any significant recommendations made.

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2022/23 and reported to the Audit Committee has been aggregated at Section 5.

The evidence-base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Trust.

In reaching this opinion we have identified that all reviews during the year concluded positively, with robust control arrangements operating in most areas.

From the opinions issued during the year, three were allocated Substantial Assurance, eight were allocated Reasonable Assurance and two were allocated Limited Assurance. No reports were allocated 'no assurance' opinion. In addition, three advisory or non-opinion reports were also issued. At the time of writing, five audits were at fieldwork stage.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Trust's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken **one review** in this area, with a further **one in progress** planned for inclusion in the 2022/23 opinion:

- Decarbonisation (Advisory): this advisory review sought to affirm common themes across Welsh health bodies relating to Decarbonisation Action Plans and to provide an overview of the overarching position across NHS Wales. Our work identified that all health bodies were broadly at an early stage of implementation. Some progress was observed, but this has been restricted by the availability of financial and staff resource.
- Follow Up: this review received a reasonable assurance opinion. We considered timely implementation of internal audit recommendations and governance of the Audit Action Tracker. We also followed up on recommendations contained in our 2021/22 Trust Assurance Framework, Board Committee Effectiveness and Follow-up of Previous Recommendations reports. We found that nine of the thirteen recommendations followed up had been fully implemented and the remaining four had been partially implemented. Of the four, one was deemed to be medium priority (continued improvement to Audit Action Tracker governance) and three were low priority.

Strategic Planning, Performance Management & Reporting

We have undertaken **one audit** in this area, with a further **one in progress** planned for inclusion in the 2022/23 opinion:

- Performance Management Framework (PMF): receiving a reasonable assurance opinion, this review provided assurance over phase 1 of evolving the Trust's PMF and planned actions for phases 2 and 3. We found the Trust to have developed a comprehensive new PMF reporting format, with phase 1 having been well managed. We did not identify any significant matters for reporting.
- Trust Priorities: this audit aimed to provide assurance over the robustness of the Trust's prioritisation exercise and the governance mechanisms over the delivery of priority programmes. It received a reasonable assurance opinion. No significant matters for reporting were identified, although we flagged areas where the prioritisation approach could be used to enhance annual financial and resource planning.

Financial Governance and Management

Under this domain, we undertook **one review**:

- Finance & Service Sustainability: focusing on the fundamental processes underpinning financial and service sustainability – namely budgetary control (revenue budgets) and savings plans – we provided a reasonable assurance opinion on this audit. No significant matters for reporting were identified, although we flagged several areas where improvement was needed to comply, or demonstrate compliance, with the Standing Orders / Standing Financial Instructions and Budgetary Control FCP.

Audits at other bodies: the audits of the payment systems provided by NWSSP, which we audit each year, concluded with positive assurance. The audits of Payroll and Accounts Payable both received reasonable assurance opinion ratings. Additionally, the audit of Procurement Services – National Sourcing also received a reasonable assurance opinion.

Quality & Safety

Three reviews were planned under the Quality & Safety domain, of which **two were completed** and one deferred.

Completed audits:

- Clinical Audit: receiving a reasonable assurance opinion, the audit considered the Trust's Clinical Audit Strategy and Plans and the governance mechanisms over clinical audit activities, specifically around improvement actions and learning. We highlighted recommendations to support the Trust's ongoing journey in improving clinical audit.
- Patient & Donor Experience: our review identified that the Trust has patient and donor experience governance, reporting and scrutiny mechanisms in place, is using technology to capture feedback data, and is using this data to identify and implement service improvements. We provided a reasonable assurance opinion, having identified areas where further work is needed to ensure the mechanisms in place are robust and embedded throughout the Trust.

Deferred audits:

- Quality & Safety Framework: we agreed to defer this audit to the 2023/24 plan due to the overlap with the Audit Wales Quality Governance report, which was presented to the Trust's Quality, Safety & Performance Committee in November 2022.

Information Governance & Security

We undertook **three reviews** in this area:

- Digital Health & Care Record (DHCR) – Implementation: this audit considered the Trust's preparedness for the November 2022 'go live' of the DHCR solution and received a substantial assurance opinion. We did identify any matters for reporting;
- Cyber Security: this report considered improvement work and progress against the Trust's Cyber Security Strategic Delivery Plan (the CSSPD), cyber security reporting, and back-up procedures. Whilst we found that the Trust had made good progress with its cyber security improvements and the report received a substantial assurance opinion, we noted that recent resource pressures had slowed progress against the CSSDP.
- Information Governance: we provided a reasonable assurance opinion on this audit, concluding that the Trust has an active Information Governance function which is engaged in the ongoing development and enhancement of the Trust's information governance activities. Most of the findings identified were already included in the Trust's Information Governance Development Plan. No significant matters were identified for reporting.

Audits at other bodies: five audits which may provide assurance to the Trust were undertaken as part of the DHCW internal audit plan. The Technical Resilience and Cyber Security audits received substantial assurance opinions. Audits of Switching Services, Embedding the Stakeholder Engagement Plan and the Microsoft 365 Centre of Excellence received reasonable assurance opinions.

Operational Service and Functional Management

Two audits were undertaken under this domain:

- Managing Attendance at Work: overall, we concluded that the Trust's processes regarding managing attendance at work were adequately designed, with robust performance reporting and monitoring processes. Whilst a reasonable assurance opinion was given, we identified issues around absence documentation not being stored in the appropriate location and delays in holding Long Term Sickness meetings.
- Research & Development: we provided a substantial assurance opinion over this review, which considered the governance and management arrangements over the Trust's research and development function. We did identify any matters for reporting. The positive outcome was a result of the focus and work undertaken by the Trust in this area.

Workforce Management

We undertook **one review** under this domain:

- Staff Wellbeing (Advisory): this advisory review sought to consider the effectiveness of staff wellbeing support and initiatives utilised by the Trust, including throughout the Covid-19 pandemic. We identified that the Trust has significant wellbeing activity ongoing, including numerous interventions to support wellbeing improvement. We identified areas that we considered could be enhanced or strengthened around measures for monitoring success of interventions and consideration of standard wellbeing frameworks, models or research.

The Managing Attendance at Work audit, detailed under the Operational Service and Functional Management domain above, also falls into the Workforce Management domain.

Audits at other bodies: the Recruitment Services audit undertaken as part of the internal audit programme at NWSSP received a reasonable assurance opinion.

Capital & Estates Management

We have undertaken **five audits** in this area. This includes audits within the Integrated Audit & Assurance Plans (IAAPs) for the nVCC Enabling Works and nVCC Main Scheme projects.

Reviews within the general annual Internal Audit Plan:

- Capital Systems: this audit – which received a reasonable assurance opinion – evaluated the Trust's systems for the prioritisation and allocation of discretionary capital. We concluded that a robust procedural framework was in place with compliance generally evident at divisional level, although recommendations were made to strengthen governance within the framework.

Integrated Audit & Assurance Plans:

In accordance with the Welsh Government's NHS Wales Infrastructure Investment Guidance, the new Velindre Cancer Centre (nVCC) Outline Business Case (OBC) and Enabling Works Full Business Case (FBC), we have sought to provide the integrated audit approach at the project(s) during 2022/23. This included ongoing observation at key project meetings, interim audit reviews and ad hoc input as required by Trust management.

The 2022/23 completed audits included:

- nVCC Enabling Works (b/f 2021/22) – reasonable assurance;
- nVCC Enabling Works Security Contract – advisory; and
- nVCC Contract Management – limited assurance.

During 2022/23, audit activity continued to focus on the delivery of the enabling works (EW) contract. Our initial review (to January 2023), identified significant concerns associated with the slippage in the works programme. This effectively meant that at the date of the audit fieldwork, the EW project completion no longer aligned with the original target for Financial Close for the nVCC project, which ultimately could impact on the progression and delivery of the main works. However, recognising subsequent changes in the critical timelines (primarily financial close), it is important that these are acknowledged, and accordingly further audit work is to be progressed during 2023/24 to reflect and consider the new delivery timetable.

Noting the above, the following IAAP audits planned for 2022/23 were deferred to 2023/24:

- nVCC Design & Change Management;
- nVCC Planning; and
- nVCC Procurement & Approvals.

Our access has been limited due to project development pressures and we acknowledge the balance required between accessing management at critical stages and delivering the agreed audit programmes.

We will seek to continue to provide an integrated audit provision at the project ensuring appropriate focus through to the delivery and commissioning of the new facility. To enable the same, Executive support and management engagement is required to enable the update of the integrated audit plan for inclusion within the FBC (now scheduled for submission for scrutiny during Winter 2023).

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports.

In 2022/23, we considered progress made on a risk-based sample of findings from 2021/22 reports, focusing mainly on high and medium priority findings from key reports, namely the Trust Assurance Framework, Board Committee Effectiveness and Follow-up of Previous Recommendations. We also undertook testing on the completeness, accuracy and effectiveness of the Audit Action Tracker. Our work identified that:

- nine of the thirteen recommendations followed up had been fully implemented; and
- the remaining four had been partially implemented. Of these, one was deemed to be medium priority (continued improvement to Audit Action Tracker governance) and three were low priority.

We provided a reasonable assurance opinion over the 2022/23 follow-up audit.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

We have considered the impact of our follow-up work on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on this previous years' programmes makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Trust, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2022/23 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Trust's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2022/23.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales.

In addition, at least once every five years, we are required to have an External Quality Assessment (EQA). This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023. CIPFA concluded that NWSSP's Audit & Assurance Services 'fully conforms' with the Public Sector Internal Audit Standards. It is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audits at Trust in conformance with the Public Sector Internal Audit Standards for 2022/23.

Our conformance statement for 2022/23 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2022/23 which will be reported formally in the Summer of 2023;
- the results of the work completed by Audit Wales; and
- the results of the EQA undertaken by CIPFA in 2023.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2022/23 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Trust's audit programme for 2022/23.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE TRUST

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership; and
- Digital Health & Care Wales.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership, a hosted body of Velindre University NHS Trust, several audits were undertaken which are relevant to the Trust. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Trust, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP Accounts Payable service.
Payroll (draft report)	Reasonable	To evaluate and determine the adequacy of the systems and controls in place for the management of Payroll Services.
Recruitment Services	Reasonable	To review the adequacy of the systems and controls in place for the management of Recruitment Services.
Procurement Services – National Sourcing (draft report)	Limited	To review the consistency of operations with Procurement Services – National Sourcing and to ensure that procurement procedures are being complied with.
Decarbonisation	Advisory	To affirm common themes across Welsh health bodies relating to Decarbonisation Action Plans and provide an overview of the overarching position across NHS Wales.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, several audits were undertaken which are relevant to the Trust. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Technical Resilience	Substantial	To establish and assess the organisation's position to maintain acceptable service levels through, and beyond, severe disruptions to its critical processes and the IT systems which support them.
Switching Services	Reasonable	To ensure that the Switching Service is maintained appropriately and that risks to the operation of the service are appropriately managed.
Cyber Security	Substantial	To provide an opinion over whether appropriate progress has been made with the improvement plan.
Centre of Excellence	Reasonable	To provide an opinion over the controls for the establishment of the Microsoft 365 Centre of Excellence
Embedding the External Stakeholder Engagement Plan	Reasonable	To provide an opinion over the arrangements for the embedding of the External Stakeholder Engagement Plan.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre University NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2023/24 operational audit plan.

The audit plan approved by the Committee in May 2022 contained 14 planned reviews (excluding the separately agreed Integrated Audit and Assurance Plans for the new Velindre Cancer Centre and related Enabling Works). Changes have been made to the plan, with one audit deferred and one audit added. All these changes have been reported to and approved by the Audit Committee. As a result of these agreed changes, we have delivered 14 reviews under the core audit plan.

Additionally, we have delivered three reviews relating to the nVCC and Enabling Works Integrated Audit and Assurance Plans. A further four 2022/23 planned IAAP reviews were deferred to the 2023/24 plan to align with nVCC project progress, including where reporting on our Enabling Works audit was paused to undertake further work to reflect on subsequent changes in the project critical timeline.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Trust. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

To monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	May 2022[1]	By April 2022	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2022/23	G	100%	100%	v>20%	10%<v<20%	v<10%

[1] Early May 2022 Audit Committee

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	88%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	53%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%
Audit reports to agreed Audit Committee	G	Yes	Yes	No	N/a	Yes

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 18 audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2

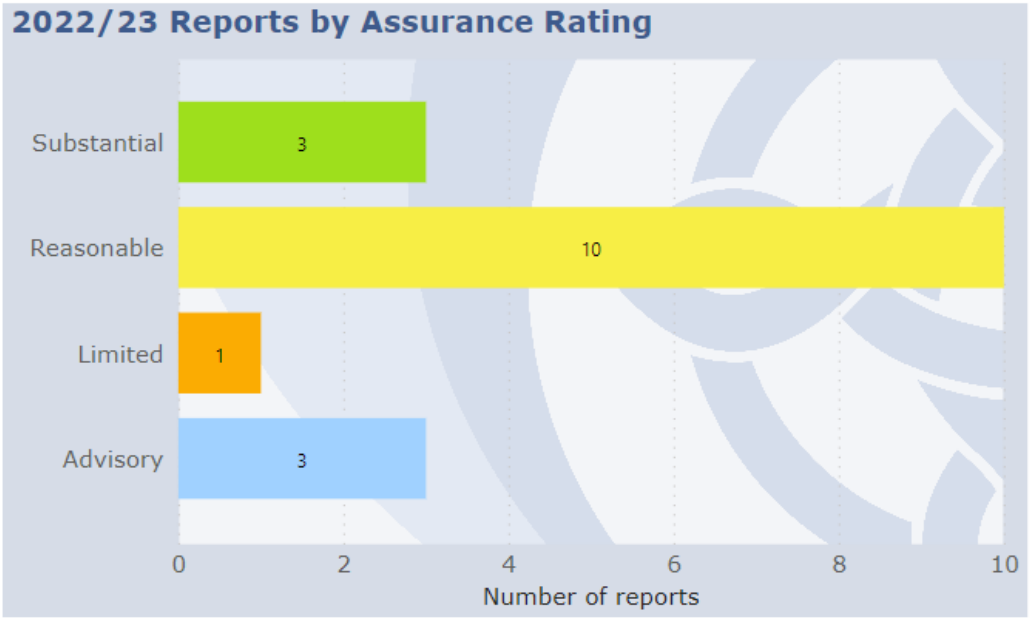


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP and DHCW.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Digital Health & Care Record – Implementation	To provide assurance that the Trust was prepared for the November 2022 'go live' date for the DHCR. This audit focused on the process for managing the implementation of DHCR, it did not provide assurance on the ongoing, successful use of the solution.
Research & Development	To provide assurance that there are effective systems, processes and governance in place around the Trust's research and development function, including partnership working.
Cyber Security	To ensure the Trust is working to improve its cyber security position, and that appropriate reporting is in place that shows the status. Also included assurance over cyber security back-up and procedures.

5.3 Reasonable Assurance (Yellow)

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Trust Priorities	To provide assurance over the robustness of the Trust's prioritisation exercise and the governance mechanisms over the delivery of priority programmes.
Capital Systems	To evaluate the process and procedures operating to support the prioritisation and allocation of the Trust's discretionary capital funds.
Clinical Audit	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.

Review Title	Objective
Managing Attendance at Work	To ensure the Trust is adequately managing staff sickness absence at a divisional, directorate and operational service group level.
Finance & Service Sustainability	To review the arrangements within the Trust to ensure sustainability of services. Our 2022/23 review focused on the fundamental processes underpinning financial and service sustainability, namely budgetary control (revenue budgets) and savings plans.
Information Governance *This audit replaced the deferred audit in section 5.7.*	To assess the effectiveness of the Trust's Information Governance processes and provide assurance that principles and practices are followed and working as intended.
nVCC Enabling Works (deferred from 2021/22)	To determine the adequacy of arrangements in place at the Enabling Works project, forming part of the wider nVCC project (covering the period from May 2021 to June 2022).
Patient & Donor Experience	To review the Trust's processes for capturing patient and donor reported experience measures, and how data is used to effectively inform service improvement.
Performance Management Framework	To provide the Trust with assurance over phase 1 of evolving its PMF and actions for phases 2 and 3.
Follow-up of Prior Year Recommendations	To provide the Trust with assurance that: • recommendations are implemented in a timely manner and have addressed identified risks; and • the Audit Action Tracker provides complete and accurate updates on progress to the Audit Committee.

5.4 Limited Assurance (Amber)

In the following review areas, the Board can take **limited assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. More significant matters require management attention in either control design or operational compliance and these will have moderate impact on residual risk exposure until resolved.

Review Title	Objective
nVCC MIM Contract Management *This audit included follow-up of previously agreed management actions; therefore no separate follow-up report was produced for the IAAP.*	To determine whether appropriate contract management arrangements were in place, and operating effectively, for technical and advisory services that have been procured to: • widen the areas of expertise available to the project; and • strengthen the support provided in development of project deliverables.

5.5 No Assurance (Red)

No reviews were assigned a **'no assurance'** opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Staff Wellbeing	To consider the effectiveness of staff wellbeing support and initiatives utilized by the Trust, including throughout the Covid-19 pandemic, and to determine if improvements can be made through consideration of the approaches within other NHS organisations.
nVCC Enabling Works Security Contract	To ensure compliance with the agreed contractual arrangements for security in place at the Northern Meadows site, and associated

Review Title	Objective
	payments, at the time of the tree clearance works (January to February 2022).
Decarbonisation	To affirm common themes across Welsh health bodies relating to Decarbonisation Action Plans and provide an overview of the overarching position across NHS Wales.

5.7 Deferred Audits

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Objective / Reason for Deferral
Quality & Safety Framework	To review key aspects of the Trust Quality and Safety Framework to ensure it is operating effectively in practice. *Deferred to the 2023/24 plan due to the overlap with the Audit Wales Quality Governance report, which was presented to the Trust's Quality, Safety & Performance Committee in November 2022.*
nVCC Enabling Works (2022/23) (draft report)	To evaluate the progression and delivery of the Enabling Works project (part of the wider nVCC project) against key business case objectives and to assess the adequacy of systems and controls in place to support its successful delivery. The audit covered the period from July 2022 to January 2023. *Further audit work is to be undertaken to evaluate the enabling works critical timeline deliverables against the revised delivery programme for the FBC and financial close for the main scheme.*
nVCC Design & Change Management	To determine whether appropriate design development and change management processes are in place at the nVCC project. *Deferred, recognising Welsh Government Scrutiny of the FBC Estates Annex.*
nVCC Planning	To evaluate and assess the adequacy of the systems and controls in place to support the successful management of planning applications, approvals and conditions of the project. *Deferred to align with progress on the nVCC project.*
nVCC Procurement & Approvals	To evaluate and assess the adequacy of the systems and controls in place to support the successful management of the MIM procurement process, and the progression through CAPs, against defined MIM procedures (including the Descriptive Document, Delegations Framework and the Procurement Strategy). *Deferred recognising other external reviews of the procurement processes.*

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2022/23 plan.

Simon Cookson

Gyfarwyddwr Archwilio a Sicrwydd / Director of Audit & Assurance
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services

Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership

July 2023

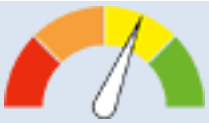
Appendix A – Conformance with Internal Audit Standards

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair. There have been no impairments to our independence during 2022/23.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2023.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk-based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.

2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B – Audit Assurance Ratings

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

AUDIT COMMITTEE

INTERNAL AUDIT PROGRESS UPDATE REPORT

DATE OF MEETING	26th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Emma Rees, Deputy Head of Internal Audit
PRESENTED BY	Emma Rees, Deputy Head of Internal Audit
APPROVED BY	Simon Cookson, Director of Audit & Assurance Matthew Bunce, Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to set out progress against the 2023/24 Annual Internal Audit Plan and key performance indicators.
RECOMMENDATION / ACTIONS	The Audit Committee is asked to: • **NOTE** the content of the progress update report; • **APPROVE** the proposed changes to the 2023/24 Internal Audit Plan; and • **IDENTIFY** if there is any action that can be taken to support improvement in the timeliness of management responses.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run	29/06/23
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS We provide a progress report to the monthly EMB Run meeting. We attend the meeting to present the report approximately quarterly, and the report is on the consent agenda for noting when we are not in attendance. On 29/06/23: • we discussed the timeliness of management responses and requested that EMB identifies further ways to support improvement thereof; and • EMB endorsed the proposed change to the 2023/24 Internal Audit Plan relating to the IRS Implementation review.	

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

APPENDICES (incorporated within progress report document)	
Appendix A	Reconciliation of Approved Annual Plan to Audits to be Delivered

1. SITUATION

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

2. BACKGROUND

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

3. ASSESSMENT

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

Key points to note:

- **2023/24 progress:** Progress is being made on our 23/24 audits; six of the 18 planned reviews are in progress and two are at the planning stage.
- **2023/24 Integrated Audit & Assurance Plan:** An updated IAAP has been developed for inclusion in the nVCC Full Business Case and will be incorporated into the 2023/24 Annual Internal Audit Plan upon FBC approval.
- **2022/23 final position:** Delivery of the 2022/23 Internal Audit Plan is complete. The Head of Internal Audit Opinion and final two 2022/23 reports will be presented at the July 2023 Audit Committee meeting.

4. SUMMARY OF MATTERS FOR CONSIDERATION

- **Changes to 2023/24 Internal Audit Plan:** We **request Audit Committee approval** for the following **proposed changes** to the 2023/24 Internal Audit Plan:
  1. IRS Implementation: we propose that the IRS Implementation review be undertaken as the planned Capital Assurance review and propose an audit of the Governance, Assurance and Risk Programme in its place.
  2. 2023/24 IAAP audits: five 22/23 IAAP audits were deferred to the 23/24 plan. We proposed that two of these (MIM Design & Change Management and MIM Procurement) are cancelled to avoid duplication with other work being undertaken by external parties (further information set out in Appendix A).
- **nVCC 2022/23 Enabling Works (EW) report:** Recognising the subsequent changes to critical timelines after our fieldwork (to January 2022), we have paused reporting and propose further audit work be undertaken during 2023/24 to consider and reflect on the new delivery timetable.
- **Timeliness of management responses:** 53% of our 2022/23 reports received timely management responses. Action to support improvement is set out on page 1 of our report and previous progress update reports. We have requested that EMB identifies ways in which it can further support this.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
NO For 2023/24 onward, individual Internal Audit reports will be linked to the strategic goals in the cover paper for each individual report, where applicable.	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance Internal Audit reports are linked to the TAF in the Annual Internal Audit Plan. For 2023/24 onward, this will also be done through the cover paper for each individual report, where applicable.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	Individual Internal Audit reports may provide assurance over the Quality Domains and Enablers. Internal Audit reports are linked to the Quality Domains and Enablers in the individual audit briefs. For 2023/24 onward, this will also be done through the cover paper for each individual report, where applicable.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: *https://www.gov.wales/socio-economic-duty-overview*	Not required for Internal Audit progress update report

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	Individual Internal Audit reports may provide assurance over the Wellbeing Goals.
	If more than one wellbeing goal applies please list below: From 2023/24 onward, Internal Audit reports will be linked to the Wellbeing Goals in the cover paper for each individual report, where applicable.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Internal Audit reports
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	From 2023/24, legal risks identified in our audits will be highlighted in the cover report for each individual report, where applicable.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Internal Audit reports are linked to the Trust Risk Register in the Annual Internal Audit Plan. For 2023/24 onward, this will also be done through the cover paper for each individual report, where applicable.
WHAT IS THE CURRENT RISK SCORE	N/a

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/a
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/a
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	N/a
All risks must be evidenced and consistent with those recorded in Datix	

Internal Audit Progress and KPI Dashboard

Velindre University NHS Trust

18th July 2023

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

Appendicies

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

Executive Summary

Alert / Escalate

Timeliness of Management Responses

- The final position for 2022/23 performance against KPI 4 (Timely Management Response) was 53%.

Improvement action being taken by Audit & Assurance Services:

Alongside previously reported actions, we:

- have included an additional page in our progress report to EMB highlighting draft reports issued and awaiting management responses; and
- are developing Internal Audit overview / guidance documents to ensure clarity on the audit process.

Action required of Trust management (reported to Jun-23 EMB):

- Greater support from EMB to ensure the provision of timely comments and management responses.

Advise

Proposed change to 2023/24 Internal Audit Plan

- We propose that the planned IRS Implementation review be undertaken as the Capital Assurance review and have identified the Governance, Assurance and Risk Programme to replace it.
- This has been agreed with the Director of Corporate Governance & Chief of Staff and was endorsed by EMB on 29/06/23.
- **We request that the Audit Committee approves this change to the 2023/24 Internal Audit Plan.**

Integrated Audit & Assurance Plan (IAAP)

2022/23 deferrals

- Five elements of the 2022/23 nVCC IAAP were deferred to the 2023/24 Annual Internal Audit Plan after it was approved.
- We now propose that two of those elements (MIM Design & Change Management and MIM Procurement) be removed from the plan to avoid duplication with work being undertaken by external parties (see Appendix A).
- **We request that the Audit Committee agree to the removal of the two elements from the nVCC IAAP.**

Advise (continued)

Enabling Works (EW)

- Our initial review (to January 2023) of the EW identified significant concerns associated with the slippage in the programme. This meant that, at the date of our fieldwork, EW project completion did not align with the original target for Financial Close for the nVCC project, which ultimately could impact on the progression and delivery of the main works.
- Recognising subsequent changes to critical timelines (primarily financial close), it is important that these are acknowledged. Accordingly, further audit work is proposed to be undertaken during 2023/24 to reflect and consider the new delivery timetable.
- We will also undertake an additional review prior to financial close to ensure all associated (enabling works) delivery risks are addressed.

Updated IAAP

- In accordance with the NHS Wales Investment Infrastructure Guidance, an updated draft IAAP has been developed for inclusion within the nVCC Full Business Case. The update provides and audit plan from FBC/Financial Close through to the initial operation phase of the new facility.
- The updated nVCC Audit Plan will be incorporated into the Annual Internal Audit Plan upon the FBC approval. It will be reviewed and updated annually to reflect key risks and project progression.

Assure

2022/23 Progress

Delivery of the 2022/23 Internal Audit Plan is complete, with 17 reviews having been delivered. The final two 2022/23 reports will be presented at the July 2023 Audit Committee meeting.

2023/24 Progress

Progress is being made against the 2023/24 Internal Audit Plan. Of the 18 planned reviews, 6 audits are in progress and 2 are at the planning stage.

Other activities

- Regular meetings with the Director of Finance;
- Planning meetings with various Executive Directors;
- Attendance at the 29/09/2023 EMB Run meeting; and
- Attendance at Trust Board and Committee meetings.

Overview - 2023/24

2023/24 Audit Status

* 2023/24 nVCC IAAP not yet included (except elements deferred from 2022/23, see Appendix A), to be added upon nVCC FBC approval.

2023/24 Final Reports by Assurance Rating

See assurance definitions here.

No 2023/24 reports finalised to date

Key Performance Indicators

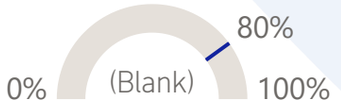
KPI1 - Timely delivery of Annual Plan & Report

Yes

KPI2 - Report delivery in line with plan

KPI3 - Timely issue of draft report

KPI4 - Timely management response



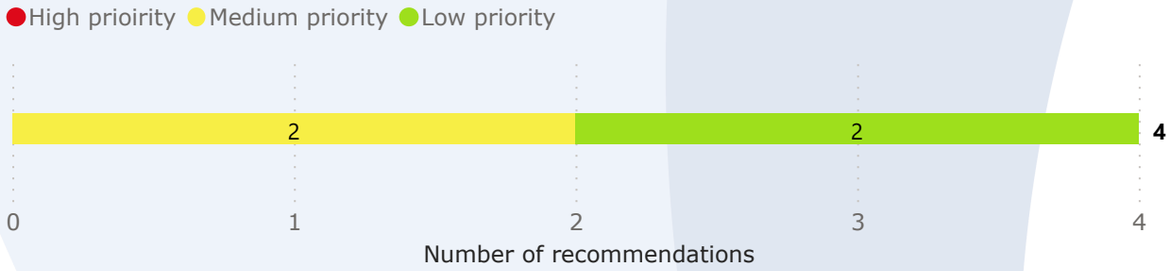
KPI5 - Timely finalisation of report

KPI6 - Delivery to planned Audit Committee

Yes

Overview of Final Reports on Consent Agenda (all 2022/23 reports)

Trust Priorities - reasonable assurance



Purpose: To provide assurance over the robustness of the Trust's prioritisation exercise and the governance mechanisms over the delivery of priority programmes.

Overview of findings:

The Trust:

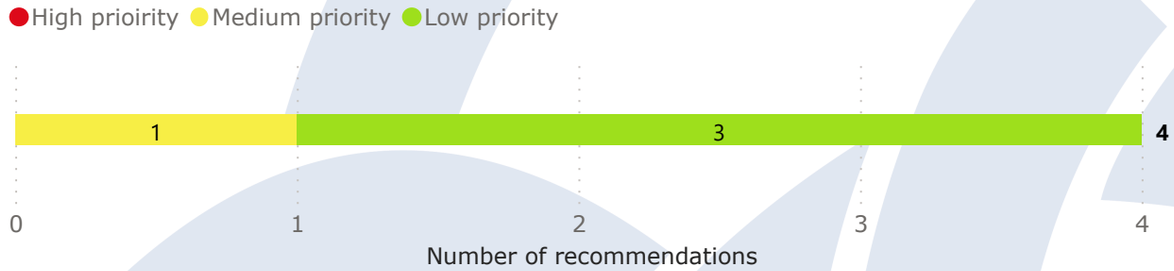
- had appropriate governance mechanisms over the prioritisaiton exercise;
- ensured clear links between the prioritisation process and the Trust Strategy (Destination 2032) and Integrated Medium Term Plan; and
- adequate overarching reporting and scrutiny arrangements are in place over the delivery of priority programmes.

The Trust acknowledges the high number of priorities for the size of the organisation and the risks this presents, and has reflected these risks in the Trust Assurance Framework.

Key matters requiring attention:

- Ensuring the deliverability section (finance & resource) is completed effectively in future years.
- Revisiting the Prioritisation Framework if overarching progress against priority delivery is not meeting milestones as planned.

Follow Up of Previous Recommendations - reasonable assurance



Purpose: To provide the Trust with assurance that:

- recommendations are implemented in a timely manner and have addressed the identified risk; and
- the Audit Action Tracker (the Tracker) provides complete and accurate updates on progress to the Audit Committee.

Overview of findings:

- We followed up on thirteen 2021/22 recommendations, including the high and medium priority recommendations from the Trust Assurance Framework, Board Committee Effectiveness and Follow Up of Prior Year Recommendations (Audit Action Tracker) reports.
- Nine of the recommendations followed up had been implemented.
- The remaining four recommendations had been partially implemented, with good progress made against all agreed actions.

Key matters requiring attention:

- Continued improvement needed to audit action tracking governance.

Note: the scope of this follow-up review provides assurance against the implementation of the agreed actions from the sampled recommendations from prior years' internal audit reports. It does not provide assurance against the full scope and objectives of the original audits.

See assurance and recommendation priority definitions here.

Appendix A: 2023/24 Reconciliation of Approved Annual Plan to Audits to Be Delivered

14
audits in 23/24 plan (approved Apr-23)

General audits added

Audit	Audit plan	Reason for addition to plan	Audit Committee approval required	Date of approval
Governance, Assurance & Risk Programme	General audit	To replace the IRS Implementation review (now being undertaken as the planned Capital Assurance review).	Yes	

Add:

1
new general audit

5
22/23 IAAP deferred

2022/23 IAAP audits deferred

Audit	Reason for deferral to 2023/24	Audit Committee approval required
nVCC Enabling Works (2022/23)	Reporting paused to consider current nVCC situation and revised financial close deadline	No
nVCC MIM Approvals	To align with nVCC project progress	No
nVCC MIM Design & Change Management	To align with nVCC project progress	No
nVCC MIM Planning	To align with nVCC project progress	No
nVCC MIM Procurement	To align with nVCC project progress	No

1
23/24 IAAP

2023/24 IAAP

Audit
Enabling Works 2

Less:

3
audits deferred/cancelled

Audits deferred or cancelled

Audit	Status	Audit plan	Reason for deferral or cancellation	Audit Committee approval required	Date of approval
Capital Assurance	Cancelled	General audit	Audit not cancelled, proposal is to do the IRS review as the Capital Assurance piece for 2023/24.	Yes	
nVCC MIM Design & Change Management	Cancelled	IAAP	To avoid duplication, NWSSP Specialist Estates Services undertaking a review as part of assurance for the FBC	Yes	
nVCC MIM Procurement	Cancelled	IAAP	To avoid duplication, external review being undertaken	Yes	

18
audits in adjusted 23/24 plan

AUDIT COMMITTEE

Counter Fraud Progress Report

DATE OF MEETING	26/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

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

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

RECOMMENDATION / ACTIONS	It is recommended that committee read and review the report and any supplementary reports in order to gain a full understanding of the work carried out by the Counter Fraud team during the relevant period.

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

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

APPENDICES	
3	NHS CFAThematic Engagement Exercise – provided as a supplementary report. (Appendices 1 and 2 contained within the body of the main report)

1. SITUATION

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

a. Counter Fraud Progress Report
b. Thematic Engagement report produced by NHS Counter Fraud Authority

2. BACKGROUND

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

3. ASSESSMENT

It is proposed that the report is noted.

4. SUMMARY OF MATTERS FOR CONSIDERATION

N/A

5. IMPACT ASSESSMENT

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

	Choose an item
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Choose an item *[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].* Counter Fraud Progress report – An administrative report only.

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

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

6. RISKS

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

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

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

NHS WALES

Counter Fraud Progress Report

01/04/23 – 30/06/2023

Public

GARETH LAVINGTON
COUNTER FRAUD MANAGER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

Table of Contents

1. Introduction

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

This report relates to activity for the reporting period 01/04/2023 – 30/06/2023.

2. Progress

Infrastructure/Annual Plan

Work has continued in maintaining the Counter Fraud infrastructure in order to maintain compliance with the Counter Fraud Plan for 2023-2024, and the NHS CFA functional standards. The below activity has taken place -

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

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

Counter Fraud - Home (sharepoint.com)

Promotion and Awareness and Educational Activity

Corporate Induction– At this point in time there is no Corporate Induction taking place at Velindre UNHST. Following liaison with the OD team it has been agreed that the

Counter Fraud will attend and deliver fraud awareness sessions at all future Corporate Induction Events. The first of these will take place on 19/07/2023 at the Welsh Blood Service, and there are further events planned throughout the year.

Fraud Pop Ups- Further fraud pop up events have been held during this quarter. This has involved the team attending Velindre CC and Velindre HQ and WBS, promoting the Counter Fraud Team, engaging with staff members and visitors, and handing out promotional materials. A flyer/bulletin has been developed and has been handed out to staff at these sessions and left in key places around the estate to encourage staff to attend Webinar events, book fraud awareness sessions, undertake e-learning and report fraud. ***A copy of this bulletin is at Appendix 1.***

Webinar Events – During this period a total of 6 webinar events have been held. These sessions are held once a month and are advertised for staff to book into. Two sessions are held – General fraud Awareness and Mandate Specific Fraud Awareness. No members of staff from Velindre UNHST have attended the webinars in this Quarter.

Intranet Site- during this Quarter the intranet site has received 409 visits.

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

A promotional email has been shared with Department Heads and Fraud Champions in order that it is cascaded to as many staff as possible which aims to increase the uptake of e-Learning, the Counter Fraud App and the uptake of Fraud Awareness sessions. A copy of this is provided at ***Appendix 2***

E- Learning – The new e-Learning package is now Live on the ESR system and available to staff. This is not mandatory learning at the organisation. Since launch 6 members of staff at VUNHST have completed the learning. During the same time period across NHS Wales as a whole 1192 members of staff have completed the learning.

Prevention

Local Bulletins – One local fraud bulletin has been produced this quarter. This was in relation to the production of false references by a former member of staff from an employment agency to a number of Healthcare Support Workers around the country. The matter has been reported to the police by the agency involved. One of these references was supplied to an applicant to CAVUHB and as a result the applicant was removed from the recruitment process. The bulletin/alert in relation to this issue was sent to other NHS Organisations in order provide awareness of the issue and protect the wider NHS organisation.

Iburn – One Iburn notice has been disseminated by the NHS Counter Fraud Authority in this Quarter. This related to a person believed to be multiple working/subcontracting out their work for multiple NHS organisations as a Finance Manager, possibly through an agency. Checks conducted on organisations ESR with no results found for details or alias. Checks conducted with organisations Fraud champion/finance department who confirmed that no person by the given details was currently or previously employed by the organisation. Results recorded on CLUE database.

FPN – No FPN's have been issued by the NHS Counter Fraud Authority in this Quarter.

Referrals

During this reporting period there have been a total of 4 referrals made to the team.

1. Related to an employee who had been suspected of working elsewhere whilst sick. The employee had already resigned from the organisation and the issue identified was of a minor nature. Advice only and the matter informally resolved without promotion to investigation.
2. Overpayment of Salary to staff member – promoted to formal investigation as below.
3. Report of money received via a Stripe bank account that was regarded as suspicious. The matter discussed with finance team and advice given. No issues re fraud and closed.
4. Suspicions raised in relation to procurement fraud by two employees. Promoted to formal investigation as below.

Investigations

Two investigations have been commenced in the reporting period as above.

1. Overpayment of staff salary – employee continued to be paid for circa 6 months following leaving the organisation. Enquiries conducted. Not suitable for prosecution. Employee contacted and repayment agreed. Case closed.
2. Procurement fraud – case ongoing. (Further details to be provided in Private meeting)

Fraud Risk

A total of 4 Fraud Risk Assessments have been completed in this period. These have been disseminated to nominated stakeholders and Executive leads for review, and consideration for recording on the local risk register, as per the Risk Management Policy.

The areas that the risk assessments have been submitted:

- Staff Sickness – False reporting
- Staff Sickness – Working Elsewhere whilst sick
- Agency – Pre-employment Checks
- Direct Recruitment – Pre-employment checks

Copies of these assessments have been submitted in the papers for the private meeting along with the live Risk Fraud Profile that provides up to date reporting of the current situation in relation to fraud risk.

National Fraud Initiative

Work has commenced into the latest NFI data dump. The below table provides the total matches that are addressed by the Counter Fraud Team. However, as NWSSP staff payroll is reported under the Velindre payroll data the majority of these matches are the responsibility of the NWSSP LCFS.

Report Type	Total No. of Matches	No. Cleared
Payroll to Payroll - NI	623 (20 Velindre)	5
Payroll to Payroll - Tel. No.	18 (7 Velindre)	1
Payroll to Payroll - Email	0	NA
Payroll to Pension	29 (9 Velindre)	0
Payroll to Company Director/Trade Creditor	26 (6 Velindre)	0
Payroll to Creditor	19 (17 Velindre)	0

3. Other

NHS Counter Fraud Thematic Engagement Exercise – Fraud Risk

On 6th June 2023 the NHS Counter Fraud Authority reported on a 'Thematic Engagement Exercise' that they had undertaken into compliance with the Government Functional Standard GovS 013: Counter Fraud; requirement 3 Risk assessment. This document is provided under separate cover and submitted as supplementary to this progress report as ***Appendix 3***. The document outlines the background and scope of the exercise and identifies its findings and recommendations for NHS Wales as a whole and for each individual Health Board. These are summarised below and the actions being undertaken by the Counter Fraud Team provided alongside.

This has been reported to the Audit Committee, in support of the Annual Report that also reported on this at the last meeting, to provide assurance that in this requirement area the CAVUHB Counter Fraud Team are compliant.

Generic Recommendations (Responses, where appropriate, in ***bold Italic***)

- NHSCFA to provide continued support and training to organisations via workshops or webinars in order to increase knowledge and understanding of both fraud risk assessments and LPEs.

- NHSCFA to reinforce the importance of fraud risk assessments and the targeted approach to LPEs so that LCFS resources are best spent more effectively.

- NHSCFA to explore the possibility of allowing access to Ngage for key staff within an organisation for eg deputy directors of finance, head of governance and head of risk.

- Organisation must record FRAs in-line with their own risk management policies to achieve an amber rating and once evidence supports review and evaluation in-line with those policies then a green rating would apply for requirement 3 – ***This is already being carried out. All Fraud Risk Assessment work is recorded on the local form created for the purpose and is reported to nominated stakeholders and Executive leads for review, recording on the local risk register, consideration for escalation, and any recommended remedial action to be undertaken.***

- Organisations to undertake comprehensive fraud risk assessments at a local level which should be reviewed and updated in line with the organisations own policies and procedures – ***as above with the addition that a local live Fraud Risk Profile is held by the Counter Fraud Team with review dates and actions to be completed.***

- Organisations must ensure that all FPNs are recorded on Clue as this will ensure the benchmarking dashboards accurately reflect the work being done to counter fraud at a local level. Failure to do so would result in a red rating for requirements 6, 8 and 10. – ***this is already being completed***.

- Organisations to ensure outcomes from LPEs must be accurately recorded even if this is some time after the proactive exercise has concluded. For example, following recommendations it would be beneficial to revisit the exercise to review outcomes. – ***this is completed as an when appropriate. All LPE records remain live on the clue system and contain regular dates of review.***

Organisational Findings and Recommendations

Findings

'We did not have sight of FRAs for the organisation. However, we did engage with the LCFS for Shared Services Wales and expect FRAs to be written and recorded for this service arm of Velindre. LPE's and FPNs had been recorded and at the time of the assessment a total of 4 had been recorded on Clue for the period 01/04/2021 to

01/09/2022.' – ***this is a confused statement. Liaison was made with the CFA team at the CAVUHB offices in relation to this matter in October 2022 where discussion in relation to the VUNHST took place and the recorded work on CLUE was made available. The LCFS for SSP does not carry out Fraud Risk assessment activity for VUNHST.***

Recommendations

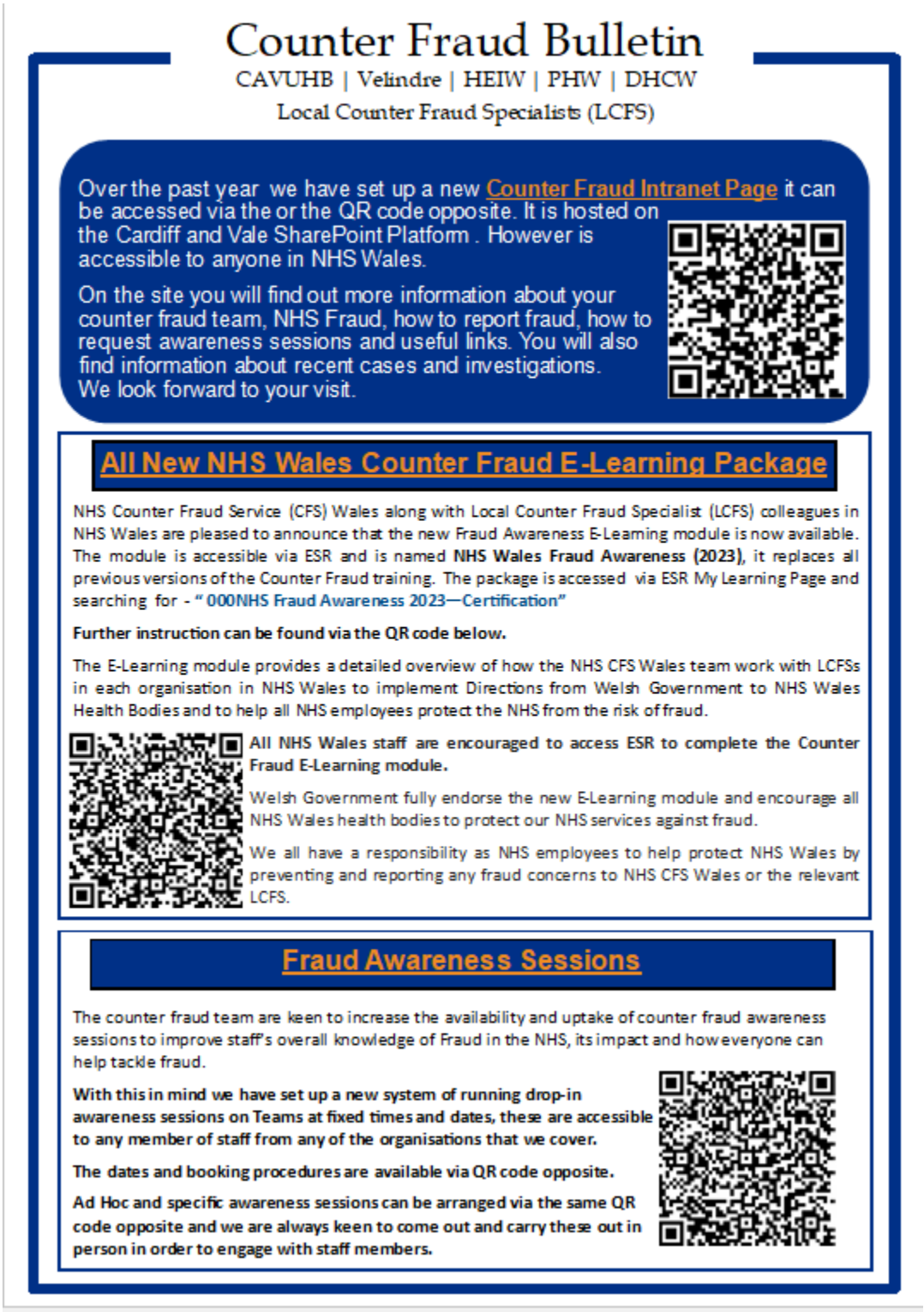
- The organisation should ensure that FRAs are completed, recorded and managed in-line with local policy. A red rating will apply for requirement 3 until this work is completed – ***the Fraud Risk work carried out is already compliant with GCFP content and local policy requirements. All fraud risks are reported to the organisational stakeholders, and the corporate governance team in order to ensure successful inclusion on the Datix database that is used by the organisation to record risk. Further to this a live Fraud Risk Profile is maintained by the Counter Fraud team for the purposes of status and review. All risk work is also recorded on the CLUE database.***

- Outcomes from LPEs should be accurately recorded – ***these are being recorded as above on the CLUE database.***

- All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10. – ***this is an incorrect statement. All FPN's issued by the NHS CFA have been actioned in a timely fashion and have been recorded on the CLUE Database accordingly. Further to this all FPN's that are issued are always presented to the Audit Committee along with actions undertaken.***

4. Appendices

Appendix 1 – Flyer used for promotion



Counter Fraud Bulletin

CAVUHB | Velindre | HEIW | PHW | DHCW

Local Counter Fraud Specialists (LCFS)

Over the past year we have set up a new Counter Fraud Intranet Page it can be accessed via the or the QR code opposite. It is hosted on the Cardiff and Vale SharePoint Platform . However is accessible to anyone in NHS Wales.

On the site you will find out more information about your counter fraud team, NHS Fraud, how to report fraud, how to request awareness sessions and useful links. You will also find information about recent cases and investigations. We look forward to your visit.

All New NHS Wales Counter Fraud E-Learning Package

NHS Counter Fraud Service (CFS) Wales along with Local Counter Fraud Specialist (LCFS) colleagues in NHS Wales are pleased to announce that the new Fraud Awareness E-Learning module is now available. The module is accessible via ESR and is named **NHS Wales Fraud Awareness (2023)**, it replaces all previous versions of the Counter Fraud training. The package is accessed via ESR My Learning Page and searching for - **" 000NHS Fraud Awareness 2023—Certification"**

Further instruction can be found via the QR code below.

The E-Learning module provides a detailed overview of how the NHS CFS Wales team work with LCFSs in each organisation in NHS Wales to implement Directions from Welsh Government to NHS Wales Health Bodies and to help all NHS employees protect the NHS from the risk of fraud.

All NHS Wales staff are encouraged to access ESR to complete the Counter Fraud E-Learning module.

Welsh Government fully endorse the new E-Learning module and encourage all NHS Wales health bodies to protect our NHS services against fraud.

We all have a responsibility as NHS employees to help protect NHS Wales by preventing and reporting any fraud concerns to NHS CFS Wales or the relevant LCFS.

Fraud Awareness Sessions

The counter fraud team are keen to increase the availability and uptake of counter fraud awareness sessions to improve staff's overall knowledge of Fraud in the NHS, its impact and how everyone can help tackle fraud.

With this in mind we have set up a new system of running drop-in awareness sessions on Teams at fixed times and dates, these are accessible to any member of staff from any of the organisations that we cover.

The dates and booking procedures are available via QR code opposite.

Ad Hoc and specific awareness sessions can be arranged via the same QR code opposite and we are always keen to come out and carry these out in person in order to engage with staff members.

NHS Wales Counter Fraud APP

We are pleased to announce the launch of the new NHS Wales Counter Fraud App, available to all NHS Wales staff. Our goal with this app is to increase awareness and education of fraud in the workplace and to make reporting fraud as accessible as possible for all NHS Wales staff.

Features include the latest news, fraud reporting, convictions in Wales, and resources such as the fraud awareness toolkit.

Additionally, the app will feature fraud awareness videos and a section where you can easily contact your local counter fraud specialist.

We encourage you to download the app and take advantage of the resources and tools it offers. (Power Apps is required for this and you may need to request this access from your IT Team)

For more information on how to download the NHS Wales Counter Fraud Service App please visit the NWSSP Intranet Pages or scan the QR code below

Thank you

Your Local Counter Fraud Team.

NHS fraud. Spot it. Report it. Together we stop it.

Local Counter Fraud Team

The Counter Fraud Department has a **new online reporting tool** which can be accessed by scanning the QR Code below. There is also a new generic email inbox which can be used to contact the team. Any information provided is treated **confidentially**.

Counter Fraud Enquiry Form

CounterFraudEnquiries.CAV@wales.nhs.uk

Gareth Lavington
Tel: 029218 36265
Gareth.Lavington2@wales.nhs.uk
Counter Fraud Manager

Henry Bales
Tel: 029218 36264
Henry.Bales@wales.nhs.uk
Deputy Counter Fraud Manager

Nicola Tillings
Tel: 029218 36481
Nicola.Tillings2@wales.nhs.uk
Local Counter Fraud Specialist

Office: Counter Fraud Department, 1st Floor Woodland House, Maes-Y-Coed Road, Cardiff, CF14 4HH

Appendix 2 – Promotional Email sent to Dept. Heads, Fraud Champions

"Dear Colleagues

We are pleased to announce that the new Fraud Awareness E-Learning module is now available. The module is accessible via ESR and is named **NHS Wales Fraud Awareness (2023)**, it replaces all previous versions of the Counter Fraud training.
The package is accessed via ESR My Learning Page and searching for -

" 000NHS Fraud Awareness 2023—Certification"

Full instruction on accessing and completing the course can be found here: Online Learning (sharepoint.com)

The E-Learning module provides a detailed overview of how the NHS CFS Wales team work with LCFSs in each organisation in NHS Wales to implement Directions from Welsh Government to NHS Wales Health Bodies and to help all NHS employees protect the NHS from the risk of fraud.
All NHS Wales staff are encouraged to access ESR to complete the Counter Fraud E-Learning module.
Welsh Government fully endorse the new E-Learning module and encourage all NHS Wales health bodies to protect our NHS services against fraud. We all have a responsibility as NHS employees to help protect NHS Wales by preventing and reporting any fraud concerns to your Local Counter Fraud Specialists. (Counterfraudenquiries.Cav@wales.nhs.uk)

In addition, the counter fraud team are keen to increase the availability and uptake of counter fraud awareness sessions to improve staff's overall knowledge of Fraud in the NHS, its impact and how everyone can help tackle fraud.
With this in mind we have set up a new system of running drop-in awareness sessions on Teams at fixed times and dates, these are accessible to any member of staff from any of the organisations that we cover.
We will be running general fraud awareness sessions and specific mandate fraud awareness sessions (Finance Staff). These will be half hour sessions with a presentation and time for questions and answers at the end.
There is a registration form (click on the date you wish to attend) which you will need to complete in order to receive the link to the session and add it to your calendar.

The dates and booking procedures are available here: Fraud Awareness Sessions (sharepoint.com)

Ad Hoc and specific awareness sessions can be arranged also at the above link and we are always keen to come out and carry these out in person in order to engage with staff members.

Finally, we are pleased to announce the launch of the new NHS Wales Counter Fraud App, available to all NHS Wales staff. Our goal with this app is to increase awareness and education of fraud in the

workplace, and to make reporting fraud as accessible as possible for all NHS Wales staff. Features include the latest news, fraud reporting, convictions in Wales, and resources such as the fraud awareness toolkit. Additionally, the app will feature fraud awareness videos and a section where you can easily contact your local counter fraud specialist.
We encourage you to download the app and take advantage of the resources and tools it offers. (Power Apps is required for this and you may need to request this access from your IT Team)
For more information on how to download the NHS Wales Counter Fraud Service App please click the link below

Counter Fraud Service Wales app (sharepoint.com)

Best wishes

The Cardiff and Vale UHB Counter Fraud Team

As requested above, please could you assist with dissemination of this email/or the information contained within, in order that it filters through to Departmental/Directorate Managers within your organisation in order to assist with the uptake of Fraud Awareness and Education. We will be arranging dates in the near future to get out and about to spend a day at each organisation visiting and engaging with staff, delivering promotional materials and holding Counter Fraud surgeries. Dates and locations will be confirmed in due course.

Many Thanks for your assistance in advance, “”

Appendix 3 – Thematic Engagement report NHS CFA - provided separately

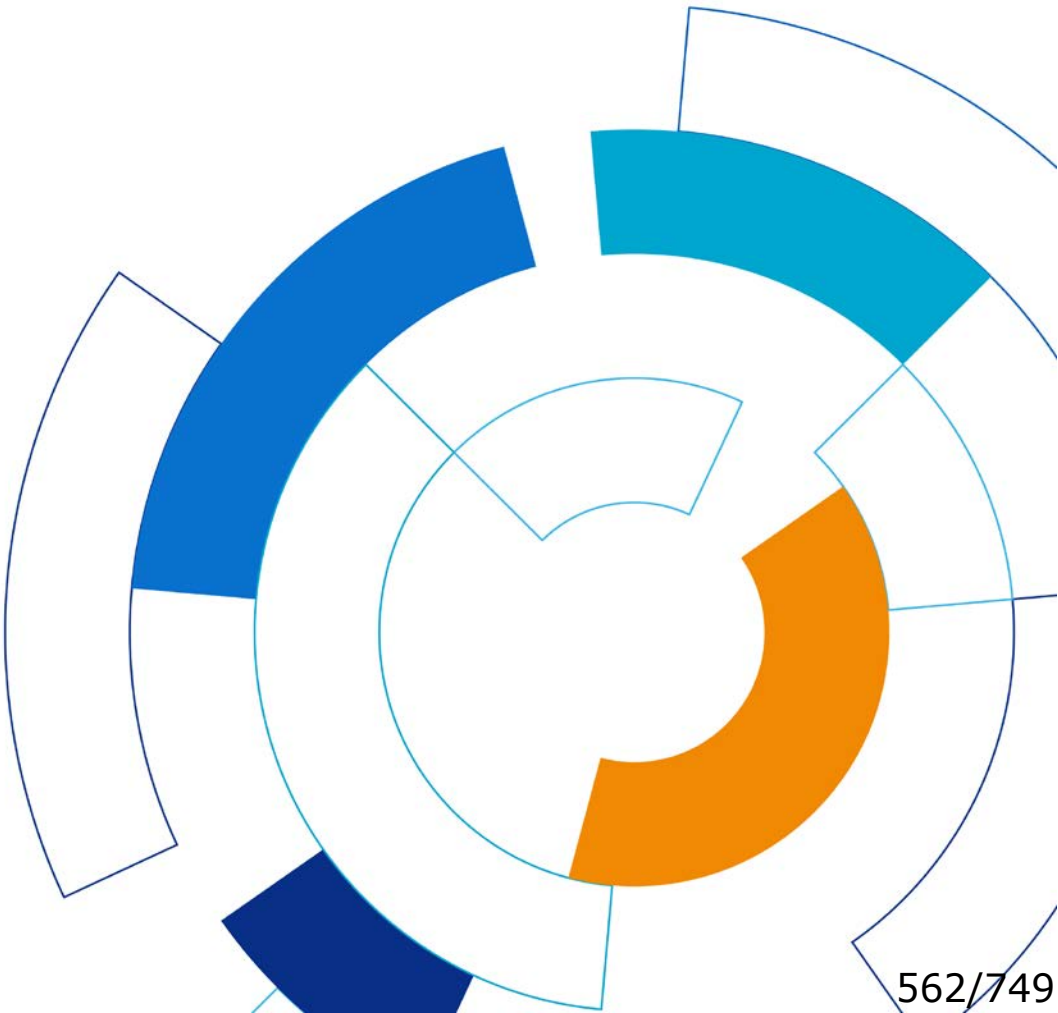
NHS Counter Fraud Authority

RISK BASED LOCAL PROACTIVE WORK

Thematic Engagement Exercise

JUNE 2023

Version 1.0 Final version



NHS fraud.
Spot it. Report it.
Together we stop it.

Version control

Version	Name	Date	Comment
0.1	T Barlow	30 May 2023	Initial draft
0.2	J Gall	01 June 2023	Proof read and comment
1.0	T Barlow	01 June 2023	Final

Contents

Executive summary

Background

Since April 2021 all NHS funded services have been required to provide assurance against the Government Functional Standard GovS 013: Counter Fraud. To enable NHS funded services to meet the Government Functional Standard the NHSCFA released a suite of NHS Requirements in January 2021.

The NHS Counter Fraud Authority (NHSCFA) describe the requirements for these counter fraud arrangements in a set of fraud, bribery, and corruption requirements within the Functional Standard, which are published annually for both NHS funded organisations and commissioners. Welsh Government has adopted the same stance and the NHS Counter Fraud Service Wales supports compliance with the NHS Requirements.

The NHS Requirements include in component 3 the need to undertake detailed local fraud risk assessments in line with the Government Counter Fraud Profession (GCFP) standards and methodology. Furthermore, the component requires health bodies to record and manage those risk assessments in line with their own risk management policies.

The NHS Requirements include in component 6 the need to identify and report on outcome-based metrics, informed by national and local risk assessment. The outcomes to be recorded on the approved NHS case management system.

The NHS Requirements include in component 8 the need to use the case management system to record all fraud, bribery, and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during investigations and/or proactive prevention and detection exercises.

The NHS Requirements include in component 10 the need to undertake proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery, and corruption.

There is a requirement for the NHSCFA to seek assurance of compliance with these requirements from the sector and this thematic exercise will feed into the assurances sought. The findings will in turn inform future fraud landscape reports produced by the department.

Summary of findings

Firstly, we would like to thank those involved in the fraud risk assessment work and local proactive exercise (LPE) work undertaken to date and we have been encouraged by the progress made. Fraud risk assessment underpins how organisations can strategically counter fraud and more importantly at a local level ensure they have appropriate resources in place to mitigate fraud risk.

It was evident that in most cases organisations with the support of their counter fraud service provider had grasped the concepts of local fraud risk assessments and the process for conducting and recording local proactive exercises along with linking associated outcomes resulting from that work and this was encouraging.

It was pleasing that some LCFSs had worked closely with key staff at a local level to help support fraud risk work and some examples of how working closely with risk managers had expedited the fraud risk assessment process. It should however be noted that not all health boards had embraced the fraud risk assessment process and in some cases were in breach of their own policies as well as the NHS Requirements. This is reflected in both this general overarching recommendations made in this report and, in the organisation specific reports issued directly to those organisations included in the thematic exercise.

All health boards and trusts in Wales were covered in the exercise and face to face meetings were held with the LCFS leads responsible for the counter fraud provision. We would like to thank those LCFS leads for their professionalism in their approach to the exercise and their honesty of the position their organisation were in with fraud risk assessment and LPEs at the time of the exercise. We appreciate that progress will continue to be made in this area of counter fraud work and it may well be prudent to revisit the position in the future.

Suggested Next Steps

We (NHSCFA) will assist and continue to support organisations with the development of local FRAs and LPE activity through a variety of means (webinars, forums, guidance).

We (NHSCFA) will look to engage with those key members of staff responsible at a local level for fraud risk activity (Risk managers).

Organisations should continue to manage FRAs in line with their organisations risk management policy whilst ensuring the content of FRAs falls in line with the standards set by the Government Counter Fraud Profession.

Organisations should continue to undertake and record fraud risk based local proactive exercises.

Organisations should ensure fraud prevention notices are recorded as local proactive exercises on Clue in a timely manner ensuring all outcomes are recorded as appropriate.

Objectives

To undertake an exercise applied to all Health Boards and Trusts in Wales who submitted a CFFSR in June 2022, to assess the level and detail of risk-based counter fraud proactive work undertaken, with specific focus on GovS013 component 3, GovS 013 component 6, GovS 013 component 8 and GovS component 10.

To support the sector with guidance and share good practice with stakeholders to promote the benefits of shared learning and ensuring the best possible return on investment for proactive counter fraud work undertaken across the sector.

- To understand the risk based counter fraud procedures in use across NHS Provider organisations for proactive work.
- To test compliance of NHS provider organisations with regards to the four GovS 013 components relevant to this exercise (3, 6, 8 and 10) for proactive work.
- To consider appropriate guidance and continued support that the NHSCFA could provide the sector.
- Highlight good practice within the sector and communicate the findings with our stakeholders
- To report on our findings to NHSCFA and to those NHS provider organisations who formed part of the exercise (Directors of Finance, Audit Committee Chairs, Fraud Champions and Local Counter Fraud Specialists). To publicise the findings of the thematic exercise across the sector.

Purpose

The purpose of the exercise was to provide assurance to Welsh Government that appropriate measures to prevent fraud, bribery and corruption within Health Boards and Trusts for those areas of fraud risk assessment, risk based proactive exercises, outcome-based metrics and appropriate usage of the NHSCFA approved case management system (Clue) were place. Where they were not in place, to make appropriate and meaningful recommendations to address any identified vulnerabilities.

Scope / Out of Scope

The exercise engaged with all Health Boards and Trusts in Wales. Those NHS organisations that commission services (Commissioners) and any organisation falling outside the mandatory requirements of the NHS Requirements (components) were out of scope.

Methodology

Organisation Selection

There are a total of 12 organisations in Wales however Digital Health Care Wales fall under Velindre NHS Trust for reporting. Therefore 11 were selected for the exercise and those selected were.

Aneurin Bevan University LHB
Betsi Cadwaladr University LHB
Cardiff and Vale University LHB
Cwm Taf Morgannwg University LHB
Health Education and Improvement Wales
Hywel Dda University LHB
Powys Teaching LHB
Public Health Wales NHS Trust
Swansea Bay University LHB
Velindre NHS Trust
Welsh Ambulance Service NHS Trust

NHS Wales Shared Services Partnership were included under the Velindre NHS Trust findings.

The organisations were asked to provide their risk management policy and evidence of local fraud risk assessments undertaken. All organisations engaged fully with that request and submitted the required material in a timely manner which was welcomed.

In addition, Shared Services Wales took part in the exercise given they had recently appointed their own LCFS lead and the organisation carried a high level of responsibility for higher risk fraud areas such as procurement, human resources and some finance functions such as payroll for the whole of Wales.

NHS Requirements Relevant to the Exercise

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 fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy and included on the 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).

3 organisations (27%) had rated themselves as **Green** and meeting the requirement.

8 organisations (73%) had rated themselves as **Amber** and partially meeting the requirement.

Zero organisations (0%) had rated themselves as **Red** and not meeting the requirement.

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 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.

8 organisations (73%) had rated themselves as **Green** and meeting the requirement.

3 organisations (27%) had rated themselves as **Amber** and partially meeting the requirement.

NHS Requirement 8 - The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery and 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 investigations and/or proactive prevention and detection exercise**.**

10 organisations (91%) had rated themselves as **Green** and meeting the requirement.

1 organisation (9%) had rated themselves as **Amber** and partially meeting the requirement.

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 external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.

7 organisations (64%) had rated themselves as **Green** and meeting the requirement.

4 organisations (36%) had rated themselves as **Amber** and partially meeting the requirement.

Findings

Risk

We found that in most cases organisations with the continued support of their counter fraud service provider had begun to understand the concepts of local fraud risk assessments and in some instances, we were encouraged to hear that the LCFS had engaged with risk managers. It should however be noted that this was not the case for all organisations in Wales. An organisational summary is included within this report.

It was evident that there were varying degrees of compliance with NHS Requirement 3 with some organisations being at the beginning of their local fraud risk assessment work whilst others had grasped the understanding of the GCFP standard for fraud risk assessment and the importance of conducting local fraud risk assessments which would assist and inform their local proactive exercise activity and ensuring that fraud risk mitigation is undertaken and supported by hierarchy of the organisation.

Of the organisations we looked at for the thematic exercise all used Datix software to record risk assessments not all organisations had recorded their risk assessments in line with their local risk management policies and as such would be rated red for requirement 3. None of the organisations had rated themselves red on the annual CFFSR return submitted to NHSCFA. This was the area of most concern in general terms. Fraud risks should be treated and managed in the same way as any other risk formally recorded at a local level and local policies should be followed. It was also apparent that fraud was not referenced as a consideration in the local risk management policies.

We found that further support for our stakeholders will be required to reinforce the importance undertaking detailed FRAs in-line with standards and working closely with the organisations risk teams in order to better equip the organisation to fully understand their local risk areas and how then those risks can be addressed with actions.

We would encourage stakeholders to utilise the NHSCFA NGAGE platform to support their local fraud risk assessments to ensure that both the NHS Requirements and GovS013 functional standards are met.

Local Proactive Exercises (LPEs)

It was evident from the records held on Clue that the recording of LPEs and Outcomes resulting from fraud risk based LPEs was limited at the time of the assessment.

For the year 2021/22 across the 11 organisations a total of 35 LPEs had been recorded however 20 of those recorded were for 2 organisations, leaving some organisation without any recorded LPEs.

Organisations must remember that it is a requirement to record action against fraud prevention notices (FPNs) including no action required or a “not relevant” response. FPNs have been assessed centrally as posing a potential risk and therefore should be recorded locally to offer assurance to the organisation that FPNs are being actioned appropriately.

Organisations who do not record activity against FPNs could be in breach of NHS Requirements 6, 8 and 10 and the return on the CFFSR would suggest the majority of organisations would not have actually been compliant with these requirements.

We can say that more work must be undertaken to reinforce and publicise the importance of conducting fraud risk based LPEs so that limited resources are best spent more effectively with the aim of preventing and deterring fraud at a local level.

We can say that for those organisations who had recorded LPEs on Clue that the data entry was positive, and we were encouraged by the level of detail on some LPEs recorded (e.g. investigator notes). This can of course be improved with further support.

Recommendations

- NHSCFA to provide continued support and training to organisations via workshops or webinars in order to increase knowledge and understanding of both fraud risk assessments and LPEs.
- NHSCFA to reinforce the importance of fraud risk assessments and the targeted approach to LPEs so that LCFS resources are best spent more effectively.
- NHSCFA to explore the possibility of allowing access to Ngage for key staff within an organisation for eg deputy directors of finance, head of governance and head of risk.
- Organisation must record FRAs in-line with their own risk management policies to achieve an amber rating and once evidence supports review and evaluation in-line with those policies then a green rating would apply for requirement 3.

- Organisations to undertake comprehensive fraud risk assessments at a local level which should be reviewed and updated in line with the organisations own policies and procedures.
- Organisations must ensure that all FPNs are recorded on Clue as this will ensure the benchmarking dashboards accurately reflect the work being done to counter fraud at a local level. Failure to do so would result in a red rating for requirements 6, 8 and 10.
- Organisations to ensure outcomes from LPEs must be accurately recorded even if this is some time after the proactive exercise has concluded. For example, following recommendations it would be beneficial to revisit the exercise to review outcomes.

Individual organisational summaries

Organisation	Summary of findings	Recommendations
Aneurin Bevan University LHB	FRAs had been undertaken broadly in-line with GCFP methodology and had been recorded locally according to the local risk management policy. Which included recording risks on the organisations risk management software, Datix. LPE's and FPNs had been recorded and at the time of the assessment a total of 16 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. • Outcomes from LPEs should be accurately recorded and all FPNs should be actioned and recorded.
Betsi Cadwaladr University LHB	FRAs had been undertaken broadly in-line with GCFP methodology and had been recorded locally according to the local risk management policy. Which included recording risks on the organisations risk management software, Datix. LPE's and FPNs had been recorded and at the time of the assessment a total of 5 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Cardiff and Vale University LHB	A number of FRAs had been written however at the time of the assessment no FRAs had been recorded on Datix which was a policy requirement. The LCFS lead did confirm that plans had been put in place to rectify this issue. The FRAs we had sight of were	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements.

	broadly written in line with GCFP methodology. LPE's and FPNs had been recorded and at the time of the assessment a total of 7 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• FRAs should be recorded in-line with local policy as at the time of the assessment a red rating would have applied for requirement 3. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Cwm Taf Morgannwg University LHB	FRAs had been undertaken broadly in-line with GCFP methodology and had been recorded locally according to the local risk management policy. LPE's and FPNs had been recorded and at the time of the assessment a total of 2 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Health Education and Improvement Wales	We did not have sight of FRAs for the organisation. LPE's and FPNs had been recorded and at the time of the assessment a total of 5 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should ensure that FRAs are completed, recorded and managed in-line with local policy. A red rating will apply for requirement 3 until

		this work is completed. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Hywel Dda University LHB	We had sight of a number of FRAs that had been written broadly using the GCFP methodology. At the time of the assessment only 1 FRA had been recorded on the organisations Datix system. LPE's and FPNs had been recorded and at the time of the assessment a total of 2 had been recorded on Clue for the period 01/04/2021 to 01/09/2022	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Powys Teaching LHB	The risk management policy for Powys Teaching LHB stated that all risks rated 9 and below should be managed locally and intimated there was no requirement to record these risks on Datix. We had sight of a comprehensive spreadsheet of FRAs completed by the LCFS which broadly utilised the GCFP methodology.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements. I would also be prudent to ensure fraud risk ownership is relevant and department specific and therefore to

	The concern would be the local ownership of the FRAs which should be owned where the risk is relevant. For example a risk relating to procurement should be owned by the procurement team and it was not clear if this was the case. LPE's and FPNs had been recorded and at the time of the assessment a total of 2 had been recorded on Clue for the period 01/04/2021 to 01/09/2022	comply with their own policy fraud risks should be included on local departmental registers. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Public Health Wales NHS Trust	We did not have sight of FRAs for the organisation. LPE's and FPNs had been recorded and at the time of the assessment a total of 4 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should ensure that FRAs are completed, recorded and managed in-line with local policy. A red rating will apply for requirement 3 until this work is completed. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Swansea Bay University LHB	We had sight of a comprehensive spreadsheet of FRAs completed by the LCFS which broadly utilised the GCFP methodology. However, when it came to recording risks on Datix and in-line with their own policy the LCFS had found it	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local policy requirements.

	challenging at the time of the assessment to enable FRAs to be recorded on the Datix system. This meant that at that time the organisation would be rated red for requirement 3. It is important that the organisation treat fraud risks in the same way as all other risks. LPE's and FPNs had been recorded and at the time of the assessment a total of 1 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• FRAs should be recorded in-line with local policy as at the time of the assessment a red rating would have applied for requirement 3. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Velindre NHS Trust	We did not have sight of FRAs for the organisation. However we did engage with the LCFS for Shared Services Wales and expect FRAs to be written and recorded for this service arm of Velindre. LPE's and FPNs had been recorded and at the time of the assessment a total of 4 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should ensure that FRAs are completed, recorded and managed in-line with local policy. A red rating will apply for requirement 3 until this work is completed. • Outcomes from LPEs should be accurately recorded. • All FPNs should be actioned and recorded. At the time of the assessment this was not the case and would have led to a red rating for requirements 6, 8 and 10.
Welsh Ambulance Service NHS Trust	LPE's and FPNs had been recorded and at the time of the assessment a total of 17 had been recorded on Clue for the period 01/04/2021 to 01/09/2022.	• The organisation should continue to develop the detail of the local FRAs during their review being mindful of GCFP required content and local

		policy requirements, including the recording of FRAs on Datix. • Outcomes from LPEs should be accurately recorded and all FPNs should be actioned and recorded.

AUDIT COMMITTEE

PRIVATE PATIENT SERVICE - AGED DEBT

DATE OF MEETING	26/07/2023

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 and David Osborne, Head of Finance Business Partnering
PRESENTED BY	Rachel Hennessy, Interim Head of Operations and Services Delivery and David Osborne, Head of Finance Business Partnering
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

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

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

2.2 The billing delays are due to continued resourcing issues within the team due to maternity and turnover within a small function, for example medical secretary and admin support has been mostly vacant since Nov 2022. Recruitment is underway for replacement of the Private Patient Medical Secretary and wider administrative support, but it is anticipated that the post will remain vacant for a further six to eight weeks approximately. Maternity leave has recently returned on a part time basis, which has supported the recent recovery of processing volumes.

2.3 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.

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

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

Operational

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

2.5 The Private Patient Team in conjunction with Liaison have successfully realised the new income streams highlighted above, however, the issue of aged debt remains. This is being

targeted for resolution within the tenure of the present agreement by the end of August 2023. The support provided via Liaison has significantly improved the future income streams and sound governance for the Private Patients Service, however, addressing historic issues are the focus of next efforts.

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, this issue artificially inflates the issue of aged debt. 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 both within the Private Patients Team and wider Finance Function, though reviews of the current processes resulted in a corrective actions being undertaken in March period to remove duplication of invoicing identified. This action will be conducted with the support of Liaison during August 2023.

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)	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**
% Debts Payable by Insurance Companies	97.0%	95.7%	95.7%	96.4%	95.8%
% Debts Not Payable by Insurance Companies	3.0%	4.3%	4.3%	3.6%	4.2%
% Debts aged 30 days or less	13.5%	0.3%	0.0%	25.4%	0.6%
% Debts aged 31-180 days	49.8%	52.8%	49.3%	28.0%	44.5%
% Debts aged 181-365 days	13.1%	15.1%	18.2%	21.9%	27.1%
% Debts aged 1 year +	23.6%	31.8%	32.5%	24.6%	27.8%

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	**28/02/2023**	**31/03/2023**	**30/04/2023**	**31/05/2023**	**30/06/2023**
Days Sales Outstanding	134	107	115	137	135

Key Performance Indicators (Targets to be agreed)	28/02/2023	31/03/2023	30/04/2023	31/05/2023	30/06/2023
Debts recovered in month compared with total debt end of month	15.3%	29.3%	0.5%	0.5%	0.6%

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 96% 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 Mar and April periods.

2.8 The present percentage of debts less than 180 days is 45%, which when compared to average of Apr-Sep 2021 (Audited Period of Debts as Reference Point of Base for Improvement) of 45%, reflecting a return to the poor historic performance of aged debt, due to the aforementioned staffing issues which are being rectified. Whilst the aged debt issue has returned, the future income streams supported by Liaison and the enhanced governance and processing procedures provides a positive direction moving forward, with a direct focus to address the aged debt within August period, inclusive of income received but not allocated.

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

3.0 IMPACT ASSESSMENT

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

4.0 RECOMMENDATION

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

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

Appendix 1 – Aged Debt Report June 2023

Spreadsheet attached.

PP Aged Debt June 2023.xlsx

AUDIT COMMITTEE

Losses and Special Payments Report 2022/2023

DATE OF MEETING	26/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Tracy Hughes, Interim Head of Financial Operations; Chris Moreton, Deputy Director of Finance
PRESENTED BY	Chris Moreton, Deputy 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**

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

1.3 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 did 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.

2.6 Thoughout the year, the Trust made payments for the following items under the Losses and Compensation procedure, which came to the value of less that £2.5k:

2.6.1 Donation of to St David's Hospice following reported loss of a wedding ring.

2.6.2 Reimbursement following damage to shoes.

2.6.3 Reimbursement for the cost of replacing missing dentures

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. 3 payments under the Losses and Compensation procedure were issued for a total of less than £2.5k.

4. RECOMMENDATION

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

AUDIT COMMITTEE

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

DATE OF MEETING	26/07/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The purpose of this report is to advise the Audit Committee of the revisions to the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales following a review by the Welsh Government. The changes are: a) Introduction of the **Duty of Quality** and **Duty of Candour** reflecting the provisions of the **Health and Social Care (Quality and Engagement) Act 2020**;

	b) Update to reflect the change to the **Health and Care Quality Standards 2023**; c) Changes to the provisions with regard to a **Vice-Chair** of Trusts and changes to numbers of **Board Members**; d) Changes linked to the establishment of **Llais (Citizen Voice Body)** and the dissolution of the **Community Health Councils** and the **Board of Community Health Councils**; e) Temporary change to allow the Trust to hold its **Annual General Meeting** for 2023 by the end of September 2023 arising from the extended timeframe of Audit Wales audit programme of the Annual Accounts across NHS Wales.

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

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

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

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

1. SITUATION

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

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

2. BACKGROUND

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

3. ASSESSMENT

Welsh Government has undertaken a review of the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales, and have undertaken the following revisions:

a) Introduced the **Duty of Quality** and **Duty of Candour** to reflect the provisions of the **Health and Social Care (Quality and Engagement) Act 2020**;

b) Updated to reflect the change to the **Health and Care Quality Standards 2023**;

c) Made changes to the provisions with regard to a **Vice-Chair of Trusts** and changes to the **number of Board Members**, as per the **National Health Service Trusts (Membership and Procedure) (Amendment) (Wales) Regulations 2022**;

d) Made changes linked to the establishment of **Llais (Citizen Voice Body)** and the dissolution of the **Community Health Councils** and the **Board of Community Health Councils**;

e) Made a temporary change to allow the Trust to hold its **Annual General Meeting for 2023** by the **end of September 2023**.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Audit Committee is asked to **ENDORSE FOR APPROVAL** the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts for adoption by the Trust Board.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the activity outlined in this report.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
	There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report.*
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case.

	Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is essential that the Trust complies with its standing orders.

6. RISKS

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

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

Model Standing Orders

Reservation and Delegation of Powers

For NHS Trusts

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Foreword

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

They are designed to translate the statutory requirements set out in ***[delete as appropriate]*** [***For Velindre & WAST*** – the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024) as amended] [***For PHW*** – The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009 (2009/1385) as amended] into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of directors; a Scheme of decisions to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust.

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

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

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Section A – Introduction

Statutory framework

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

[***For WAST*** – Welsh Ambulance Services National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st April 1998 under the **Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998 (S.I. 1998/678)**, "the Establishment Order".]

[***For PHW*** – The Public Health Wales National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st August 2009 under **The Public Health Wales National Health Service Trust (Establishment) Order 2009 (S.I. 2009/2058)**, "the Establishment Order".]

ii) The principal place of business of the Trust is – ***[insert address]***

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

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

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v) ***[delete as appropriate]***
[***For Velindre & WAST*** – **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024)**, as amended ("the Membership Regulations") set out the membership and procedural arrangements of the Trust.]

[***For PHW*** – Under powers set out in paragraph 4 of Schedule 3 to the NHS (Wales) Act 2006 the Welsh Ministers made **The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009 (S.I. 2009/1385),** as amended ("the Membership Regulations") which set out the membership and procedural arrangements for the Trust.]

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

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

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

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

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

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

The NHS Duty of Candour statutory guidance 2023 can be found at

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https://www.gov.wales/nhs-duty-candour

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

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

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

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

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

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

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

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

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

xvi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trust and, for the purposes of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

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

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

xix) Paragraph 18 of Schedule 3 to the NHS (Wales) Act 2006 provides for NHS Trusts to enter into arrangements for the carrying out, on such terms as considered appropriate, of any of its functions jointly with any Strategic

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Health Authority, Local Health Board or other NHS Trust, or any other body or individual.

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

NHS framework

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

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

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

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

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

[For Velindre and PHW]. The Trust is considered a public body under the Act.

Deleted: the '*Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Frameworkthe

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[For WAST] The Welsh Ambulance Service NHS Trust is not, at present, considered a public body under the Act but is committed to achieving the Well-being Goals and the sustainable development principle.

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

NHS Trust framework

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

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

xxviii) NHS Trusts shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxv) below).

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

Applying Standing Orders

xxx) The SOs of NHS Trusts (together with SFIs and the Values and Standards of Behaviour Framework **[Trust to insert title of relevant policy]**), will, as far as they are applicable, also apply to meetings of any formal Committees established by the Trust, including any sub-Committees and Advisory Groups. These SOs may be amended or adapted for the

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Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.*

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

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

Variation and amendment of Standing Orders

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

- The variation or amendment is in accordance with ***[delete, as appropriate]*** [***For Velindre and WAST*** – regulation 19] [***For PHW*** – regulation 23] of the Membership Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit Committee ***[or insert name of Committee established to consider audit matters]*** and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

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

xxxv) The terms and provisions contained within these SOs aim to reflect those

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covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Board Secretary

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

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

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

Further details on the role of the Board Secretary within ***[insert name]*** NHS Trust, including details on how to contact them, is available at ***[insert signpost to relevant Trust documentation]***.

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Section B – Standing Orders

1. THE TRUST

1.0.1 The Trust's principal role is to: ***[delete as appropriate]***

[***For Velindre*** –

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

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

(c) services relating to prescribing and dispensing;

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

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

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

[***For WAST*** –

(a) to manage ambulance and associated transport services;

(b) to manage such other services (including communications and training) relating to the provision of care as can reasonably be carried out in conjunction with the management of ambulance and associated transport services from Ambulance Headquarters at:

(i) Vantage Point House, Ty Coch Way, Cwmbran, NP44 7HF
(ii) Ty Elwy, St Asaph Business Park, St Asaph, LL17 OLJ
(iii) Matrix One, Northern Boulevard, Swansea, SA6 8RE

Deleted: <#>Caerleon House, Mamhilad Park Estate, Pontypool, NP4 0XF,¶
<#>HM Stanley Hospital, St Asaph, LL17 0WA,¶
<#>Cefn Coed Hospital, Cockett, Swansea, SA2 0GP, and¶
<#>East Glamorgan General Hospital, Church Village, Pontypridd, CF38 1BS; ¶

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(c) To own the premises associated with the provision of the services in paragraphs (a) and (b);

(d) to perform the functions of the National Contact Point in Wales for the purposes of Directive 2011/24/EU as set out in regulations 3 to 6 of the National Health Service (Cross-Border Healthcare) Regulations 2013; and

(e) to provide—

(i) information about health conditions and availability of health services; and

(ii) remote access health advisory, triage and referral services,

for the purposes of the health service in Wales.

[***For PHW*** –

(a) to provide to or in relation to the health service in Wales and manage a range of public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;

(b) to develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public in Wales, to undertake the provision and commission research into such matters and to contribute to the provision and development of training in such matters;

(c) to undertake the systemic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival, and prevalence of congenital anomalies; and

(d) to provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.]

1.0.2 ***[delete as appropriate]***
[***For Velindre*** – The Trust was established by, and its functions are contained in, the **Velindre National Health Service Trust (Establishment) Order 1993** (S.I. 1993/2838), as amended. The Trust

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must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

[***For WAST*** – The Trust was established by, and its functions are contained in, the **Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998** (S.I. 1998/678), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

[***For PHW*** – The Trust was established by, and its functions are contained in, the **Public Health Wales National Health Service Trust (Establishment) Order 2009**. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

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

1.1 Membership of the Trust

1.1.1 ***[delete as appropriate]***
[***For Velindre*** – The membership of the Trust shall comprise the Chair, vice-chair, 6 non-executive directors and 6 executive directors.]

[***For WAST*** – The membership of the Trust shall comprise the Chair, vice-chair, , 6 non-executive directors and 6 executive directors.]

[***For PHW*** – The membership of the Trust shall comprise the Chair, vice-chair, 6 non-executive directors and 6 executive directors.]

1.1.2 For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively. The Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights.

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

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

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

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appoint the executive directors other than the Chief Executive.

Executive Directors

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

[***For WAST*** – A total of 6, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance and 4 others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

[***For PHW*** – A total of 6, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance and 4 others appointed by the Trust. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

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

1.1.7 ***[delete as appropriate]***
[***For Velindre*** – A total of 6 (excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services, which will include:

- A person appointed from Cardiff University.

[***For WAST*** – A total of 6 (excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services.]

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

- A person who holds a health related post in a university;
- A person with experience of local authorities in Wales;
- A person who is an employee or member of a voluntary sector organisation with experience of such organisations in Wales; and
- Three other independent members.]

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

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Use of the term 'Independent Members'

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

- Chair
- Vice-Chair
- Non-Executive Directors

unless otherwise stated.

1.2 Joint Directors

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

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

1.3 Tenure of Board members

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

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

[for PHW
The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a

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non-executive director for a total period of more than 8 years**.** Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.]

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

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

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

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

Role

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

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the Trust's performance across all areas of activity.

Responsibilities

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

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

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that member.

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

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

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

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

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

1.4.9 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They are the appointed Accountable Officer for the Trust and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

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

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2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS

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

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

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

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

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

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

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

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2.2 Delegation of Board functions

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

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

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

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

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

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

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of

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Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

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

3. COMMITTEES

3.1 NHS Trust Committees

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

Use of the term "Committee"

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

- Board Committee
- sub-Committee

unless otherwise stated.

3.2 Sub-Committees

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

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3.3 Committees established by the Trust

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

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds *[as appropriate]*;
- Remuneration and Terms of Service; and
- Mental Health Act requirements *[as appropriate]*.

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

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

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

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

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

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to

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the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

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

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

3.4 Other Committees

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

3.5 Confidentiality

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

3.6 Reporting activity to the Board

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

4. NHS WALES SHARED SERVICES PARTNERSHIP

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

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as

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amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

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

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

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

5. ADVISORY GROUPS

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

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

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

5.1 Advisory Groups established by the Trust

5.1.1 The Trust has established the following Advisory Group(s):

- Local Partnership Forum

[insert details as appropriate]

5.2 Terms of reference and operating arrangements

5.2.1 The Board must formally approve terms of reference and operating arrangements in respect of any Advisory Group it has established. These

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must establish its governance and ways of working, setting out, as a minimum:

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

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

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

5.3 Support to Advisory Groups

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

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

enabling the Board to gain assurance that the conduct of business within

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the Advisory Group accords with the governance and operating framework it has set.

5.4 Confidentiality

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

5.5 Advice and feedback

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

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

5.6 Reporting activity

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

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

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

5.7 The Local Partnership Forum (LPF)

Role

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

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

5.8 Relationship with the Board and others

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

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

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

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

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

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

6. WORKING IN PARTNERSHIP

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

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

- The Trust's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in partnerships and community groups – such as Public Service Boards – of Board members and Trust officers with delegated authority to represent the Trust and, as appropriate, take decisions on its behalf.

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

Field Code Changed

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

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

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6.1.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on Trusts in relation to the engagement and involvement of Llais in its operations.

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

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

6.1.3 The 2020 Act also places a statutory duty on the Trust to make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. The Trust must also have regard to the Code of Practice on access to premises when it comes into effect in June 2023.

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6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's

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functions, the Board shall work constructively with the Board of Llais to ensure that regional offices of Llais are involved, as appropriate, in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for changes in the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and

Engaging and formally consulting with Llais on any proposals for substantial development of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023.

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

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

Relationship with the Board

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

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

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

7. MEETINGS

7.1 Putting Citizens first

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

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where

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requested and required) and in electronic formats;
- Requesting that attendees notify the Trust of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

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

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

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7.2 Annual Plan of Board Business

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

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

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

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

Annual General Meeting (AGM)

7.2.5 The Trust must hold an AGM in public no later than the 31 July each year. [Note : this will be no later than 30 September in 2023 to take account of the timetable for audit and laying of the Accounts by Audit Wales.] At least 10 calendar days prior to the meeting a public notice of the intention to

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hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the Trust's website.

The notice shall state that:

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

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

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

7.3 Calling Meetings

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

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

7.4 Preparing for Meetings

Setting the agenda

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

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

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notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

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

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

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

Notifying the public and others

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

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

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

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

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

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

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

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

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

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

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

Addressing the Board, its Committees and Advisory Groups

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

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Chairing Board Meetings

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

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

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

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

[***For PHW:*** At least one-third of all Board members, at least one of whom

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is an Executive Director and two are Independent Members, must be present to allow any formal business to take place at a Board meeting.]

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

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

Dealing with motions

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

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

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and

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its inclusion would not adversely affect the conduct of Board business.

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

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

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

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

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

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

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

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

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the

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majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

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

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

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

7.6 Record of Proceedings

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

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

7.7 Confidentiality

7.7.1 All Board members together with members of any Committee or Advisory Group established by or on behalf of the Board and Trust officials must respect the confidentiality of all matters considered by the Trust in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as

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appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework **[Trust to insert title of relevant policy]** or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the Trust that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Trust, including Board members, Trust officers and others, as appropriate. The framework adopted by the Board framework **[Trust to insert title of relevant policy]** will form part of these SOs.

8.1 Declaring and recording Board members' interests

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

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

8.1.3 ***Register of interests*** **–** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Board Secretary, and will be updated

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

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

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

8.2 Dealing with Members' interests during Board meetings

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

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

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

(i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

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

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

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

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

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

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

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

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

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of

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

interest between their role as a Trust Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

8.3 Dealing with officers' interests

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

8.4 Reviewing how Interests are handled

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

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

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

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

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

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which

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

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case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

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

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

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

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

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

8.6 Sponsorship

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

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework [**Trust to insert title of relevant policy**] and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

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8.7 Register of Gifts, Hospitality and Sponsorship

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

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

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

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

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

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

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

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

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

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will then review and report to the Board upon the adequacy of the Trust's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

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

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

9.1 Register of Sealing

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

9.2 Signature of Documents

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

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

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework,

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how it will be assured on the conduct of Trust business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

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

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

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

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

10.1 The role of Internal Audit in providing independent internal assurance

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

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

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and

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- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

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

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

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

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

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

10.3 External Assurance

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

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

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

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

11. DEMONSTRATING ACCOUNTABILITY

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

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

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

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

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

12. REVIEW OF STANDING ORDERS

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

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

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Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

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MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

Introduction

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

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

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

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

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

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

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

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

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DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

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

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***
- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***
- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***
- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***
- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***
- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***
- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***
- ***The Board may delegate authority to act, but retains overall responsibility and accountability***
- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

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

The Board

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

The Chief Executive

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

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

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

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

The Board Secretary

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

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

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The Audit[4] Committee

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

Individuals to who powers have been delegated

Individuals will be personally responsible for:

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

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify **[Trust to insert details]** of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

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

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

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

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

[4] Trust to insert title for the committee that carries out these functions.

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SCHEDULE OF MATTERS RESERVED TO THE BOARD[5]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are: **[Trust to insert details]**
3	FULL	GENERAL	Approve the Trusts Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

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

5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the Trust's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the Trust's Values and Standards of Behaviour framework. **[Trust to insert title of relevant policy]**
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Board Secretary
11	FULL	STRATEGY & PLANNING	Determine the Trust's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and

			care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
13	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015 **[NOT APPLICABLE TO WAST)**
14	FULL	STRATEGY & PLANNING	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
15	FULL	STRATEGY & PLANNING	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
16	FULL	OPERATING ARRANGEMENTS	Approve the Trust's framework and strategy for performance management.
17	FULL	STRATEGY & PLANNING	Approve the Trust's framework and strategy for risk management and assurance.
18	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
19	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
20	FULL	STRATEGY & PLANNING	Approve the Trusts patient, public, staff, partnership and stakeholder engagement and co-production strategies.

21	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.
22	NO – Remuneration and Terms of Service Committee (For Chief Executive Committee to consist of Chair and non-Officer Members, for all other Officer members as above and to include Chief Executive)	ORGANISATION STRUCTURE & STAFFING	Appointment of the Chief Executive and Executive Directors (officer members of the Board)
23	NO – Remuneration and Terms of Service Committee (see above)	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Board Secretary

24	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
28	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
29	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
30	FULL	ORGANISATION STRUCTURE &	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups

		STAFFING	
31	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board
32	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property
33	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
34	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers

35	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Trust
36	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
37	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
38	FULL	PERFORMANCE & ASSURANCE	Approve the Trust's audit and assurance arrangements
39	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
40	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate.
41	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales, etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
42	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
43	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
44	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Trusts performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.

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45	FULL	REPORTING	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
46	FULL	REPORTING	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		[individual Trust to insert details, in accordance with statutory and Assembly Government requirements
	VICE CHAIR		[individual Trust to insert details, in accordance with statutory and Assembly Government requirements
	CHAMPION/ NOMINATED LEAD		[individual Trust to insert details, in accordance with statutory and Assembly Government requirements

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[6]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, including [individual Trust to insert details]

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

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

- **[Trusts to insert details]**
- **[Trusts to insert details]**

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

[6] As defined in Standing Orders.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

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

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[Trusts to determine]	**[Trusts to determine]**

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

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

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

Trust framework

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

- ***SFIs*** *(see Schedule 2.1 below)*
- ***Values and Standards of Behaviour Framework***
- ***Risk and Assurance Framework***
- ***Key policy documents [Trust to insert details]***

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

These documents may be accessed by:

[Trust to insert details]

NHS Wales framework

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

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR NHS TRUSTS

[NHS Trust SFIs to be inserted]

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

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

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

[Trust to insert details, including detailed terms of reference and operating arrangements for each Committee]

Schedule 4

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

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

[Trust to insert details, including detailed terms of reference and operating arrangements for each Advisory Group – as a minimum to include the Local Partnership Forum]

Local Partnership Forum Advisory Group

Terms of Reference and Operating Arrangements

1. Role and Purpose

The NHS Trust Local Partnership Forum (LPF) is the formal mechanism where NHS Wales's employers and trade unions/professional bodies (hereafter referred to as staff organisations) work together to improve health services for the people of Wales. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.

At the earliest opportunity, Trust members will engage with staff organisations in the key discussions within the Trust at the Board, LPF and Locality/Divisional levels.

All LPF members are full and equal members of the forum and collectively share responsibility for the decisions made.

The LPF will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply. These principles are attached at Appendix 1.

The purpose of the LPF will be to:

- Establish a regular and formal dialogue between the Trust's Executive Directors and staff organisations on matters relating to workforce and health service issues.
- Enable employers and staff organisations to put forward issues affecting the workforce.
- Provide opportunities for staff organisations and managers to input into organisation service development plans at an early stage.
- Consider the implications on staff of service reviews and identify and seek to agree new ways of working.
- Consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve mutually successful implementation.

- Appraise and discuss in partnership the financial performance of the organisation on a regular basis.
- Appraise and discuss in partnership the Trust services and activity and its implications.
- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.
- Communicate to the partners the key decisions taken by the Board and senior management.
- Consider national developments in NHS Wales Workforce and Organisational Strategy and the implications for the Trust including matters of service re-profiling.
- Negotiate on matters subject to local determination.
- Ensure staff organisation representatives are afforded reasonable paid time off to undertake trade union duties
- To develop in partnership appropriate facilities arrangements using A4C Facilities Agreement as a minimum standard.

In addition the LPF can establish LPF sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas. Where these sub groups are developed they must report to the Trust LPF.

2. General Principles

The Trust and LPF accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

The principles of true partnership working between staff organisations and Management are as follows:

- Staff organisations and management show joint commitment to the success of the organisation with a positive and constructive approach
- They recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
- They demonstrate commitment to employment security for workers and flexible ways of working
- They share success – rewards must be felt to be fair

- They practice open and transparent communication – sharing information widely with openness, honesty and transparency
- They must bring effective representation of the views and interests of the workforce
- They must demonstrate a commitment to work with and learn from each other

All LPF members must:

- be prepared to engage with and contribute fully to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- comply with their terms and conditions of appointment;
- equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- promote the work of the LPF within the professional discipline they represent.

A Code of Conduct is attached as Appendix 2.

3. Membership

All members of the LPF are full and equal members and share responsibility for the decisions of the LPF. The NHS organisation shall agree the overall size and composition of the LPF in consultation with those staff organisations the Trust recognises for collective bargaining. The Trade Union member of the Board will be expected to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Management Representatives

Management will normally consist of the following members of management representatives.

- Chief Executive
- Finance Director
- General Managers/Divisional Managers (as locally identified)
- Director of Workforce and OD
- Workforce and OD staff (as locally identified)

Other Executive Directors and others may also be members or may be co-opted dependent upon the agenda.

Staff Representatives

The Board recognises those staff organisations listed in Appendix 3 for the

representation of members who are employed by the Trust.

Staff representatives must be employed by the Trust and accredited by their respective staff organisations for the purposes of bargaining. If a representative ceases to be employed by the Trust or ceases to be a member of a nominating staff organisation then they will automatically cease to be a member of the LPF. Full time officers of the staff organisations may attend meetings subject to prior notification and agreement.

Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF.

Quorum

Every effort will be made by all parties to maintain a stable membership. There should be 50% attendance of both parties for the meeting to be quorate.

If the meeting is not quorate no decisions can be made but information may be exchanged. Where joint chairs agree extraordinary meeting may be scheduled within 7 calendar days' notice.

Consistent attendance and commitment to participate in discussions is essential. Where a member of the LPF does not attend on 3 consecutive occasions, the Joint Secretaries will write to the LPF member and bring the response to the next meeting for further consideration and possible removal.

4. Officers

The Staff Organisation Chair, Vice Chair and Secretary will be elected from the LPF annually. Best practice requires these three officers to come from different staff organisations.

Chairs

The Management and Staff Organisation Chairs will chair the LPF. This will be done on a rotational basis. In the absence of the Chair(s) the Vice Chair(s) will act as Chair. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the LPF in a timely manner with all the necessary information and advice being made available to LPF members to inform the debate and ultimate resolutions

Joint Secretaries

Each side of the LPF should appoint/elect its own Joint Secretary. The Management and Staff Organisation Secretary will be responsible for the

preparation of the agendas and minutes of the meetings held, and for obtaining the agreement of the Management and Staff Organisation Chairs.

The Director of Workforce and OD will act as Management Secretary and will be responsible for the maintenance of the constitution of the LPF membership, the circulation of agenda and minutes and notification of meetings.

5. Sub Committees

When is considered appropriate, the LPF can decide to appoint a subcommittee, to hold detailed discussion on a particular issue(s). Nominated representatives to sub committees will communicate and report regularly to the LPF.

6. Management of Meetings

Meetings will be held bi-monthly but this may be changed to reflect the need of either staff organisations or management.

The business of the meeting shall be restricted to matters pertaining to LPF issues and should include local operational issues. Trust wide strategic issues and issues that have Trust wide implications shall be referred to the Welsh Partnership Forum via the Board.

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The minutes shall normally be distributed 10 days after the meeting and no later than 7 days prior to meeting. Items for the agenda and supporting papers should be notified to the Management Secretary as early as possible, and in the event at least two weeks in advance of the meeting.

The LPF has the capacity to co-opt others onto the LPF or its sub groups as deemed necessary by agreement.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

AUDIT COMMITTEE

FINANCIAL CONTROL PROCEDURE UPDATE FCP 1 – BUDGETARY CONTROL PROCEDURE

DATE OF MEETING	26/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Steven Coliandris – Head of Financial Planning & Reporting
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	During a recent internal audit there was a recommendation to include within the Finance budgetary Control procedure the date that Delegated Expenditure Control letters (DECL) letters should be issued from the Chief Executive to responsible officers informing them of their expenditure budgets for that financial year. Following the audit recommendation, the line below Line has been added to the FCP (Refer to Appendix 1 - FCP 1 Budgetary Control Procedure):

	DECL Letters should be issued no later than the 30th April for the year in which the budget delegation relates.

RECOMMENDATION / ACTIONS	Audit committee is asked to **APPROVE** the changes made to the FCP.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB	29/06/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS THE FCP WAS ENDORSED FOR APPROVAL AT EMB	

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

APPENDICES	
Appendix 1	FCP 1 Budgetary Control Procedure

1. SITUATION

1.1 The Standing Financial Instructions (SFIs) of Velindre University NHS Trust detail the financial responsibilities, policies and procedures adopted by the Trust.

1.2 SFIs require that the Finance Director will "devise and maintain systems of Budgetary Control". This Budgetary Control Procedure covers the directions laid down in the SFIs and aims to provide additional guidance to budget holders.

2. BACKGROUND

2.1 The budgetary control procedure has been live for many years and was last reviewed in December 2022.

2.2 During a recent internal audit there was a recommendation to include within the FCP the date that Delegated Expenditure Control letters (DECL) letters should be issued from the Chief Executive to responsible officers informing them of their expenditure budgets for that financial year.

3. ASSESSMENT

3.1 Once the overall financial strategy & plan and individual budgets have been agreed by the Board, the Chief Executive, in their role as Accountable Officer for the Trust, will write to the COO, divisional directors and executive directors to formally delegate responsibility for holding and managing their revenue expenditure budgets for the financial year. The Chief Executive may delegate this responsibility to the Director of Finance. This letter will set out:

- the Delegated Expenditure Control Limit* (DECL) each is responsible for (identifying recurring and non-recurring budgets);
- their responsibilities as a budget holder for not exceeding the budget delegation;
- expectations that they ensure at all times propriety and regularity requirements and all other requirements for the maintenance of effective internal financial control are met and are in accordance with the Trusts Standing Orders and Standing Financial Instructions.

3.2 Following the audit recommendation the additional line has been added to the FCP (Refer to Appendix 1 - FCP 1 Budgetary Control Procedure):

- *DECL Letters should be issued no later than the 30th April for the year in which the budget delegation relates.*

4. SUMMARY OF MATTERS FOR CONSIDERATION

Including the date that DECL letters should be issued within the FCP strengthens the financial governance arrangements in allocating budgets for the financial period.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	08 - Trust Financial Investment Risk
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	Click or tap here to enter text
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: *https://www.gov.wales/socio-economic-duty-overview*	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	The procedure provides Budgetary control procedure guidance **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Click or tap here to enter text.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

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

VELINDRE UNIVERSITY NHS TRUST

FCP 1

BUDGETARY CONTROL PROCEDURE

Contents

Procedure status – Current
Procedure lead – Head of Financial Operations
Procedure issued – June 2022
Next review date – December 2023

1 SCOPE AND PRINCIPLES

1.1 The Standing Financial Instructions (SFIs) of Velindre University NHS Trust detail the financial responsibilities, policies and procedures adopted by the Trust.

1.2 SFIs require that the Finance Director will "devise and maintain systems of Budgetary Control". This Budgetary Control Procedure covers the directions laid down in the SFIs and aims to provide additional guidance to budget holders and should be read in conjunction with other relevant documents referenced in this document.

1.3 This procedure has been prepared to support adherence to the SFIs by all Directors, budget holders and employees of the Trust who have responsibilities connected with the budgetary control process.

1.4 This procedure defines the function and objectives of budgetary control and the links to the Financial Strategy.

1.5 The purpose of this procedure is:

1.5.1 To inform managers of the issues to be taken into consideration when preparing budgets and to establish a Trust wide framework within which budgetary control will operate; and

1.5.2 To assist budget holders in understanding their roles and responsibilities.

1.6 This procedure will therefore describe the whole approach to budgeting and provide a document that will enable budget holders to meet and fully utilise the responsibilities given to them.

1.7 This procedure also outlines how the divisional finance teams provide support to budget holders.

1.8 **Failure to comply with Budgetary Control Procedures may be treated as a breach of discipline.** Any Director, budget holder or employee involved in any way with the budgetary process, who is not clear as to the interpretation of this procedure or who has specific difficulty in complying with it, should in the first instance seek the advice of their line manager. If in further difficulty they should refer the matter to the Finance team.

2 DELEGATION OF BUDGETS

2.1 The Chief Executive as the accountable officer has delegated budgetary responsibility to Divisional Directors. The Divisional Directors have also been given the flexibility to further delegate to named senior managers. Divisional Directors are encouraged to delegate to the organisational level at which the use of financial

resources can be most effective. Budget holders' control must enable effective service delivery. As a result, the delegation of budgetary control will normally follow the lines of accountability described in the Trust and Divisional management structures.

2.2 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This must be documented in writing clearly stating:

- amount of the budget
- individual able to authorise expenditure
- authority to exercise virement

2.3 Any budgeted funds not required for their designated purposes revert to the control of the Chief Executive or Director of Finance, subject to the appropriate authorised virement.

2.4 Wherever possible budget holders should be allowed to retain planned underspend for alternative use providing that sound proposals can be put forward which will not jeopardise the Trust's overall commitment to achieving breakeven on the income and expenditure account.

2.5 Non-recurring budgets must not be used to finance recurring expenditure without the authority in writing of the Chief Executive or Director of Finance.

3 BUDGET HOLDER RESPONSIBILITY

3.1 Budget holders have the support of a divisional finance team and the Head of Finance Business Partnering. The divisional finance team will be headed by a Senior Finance Business Partner who will be the key point of contact for the budget holder in the discharge of their financial responsibilities.

3.2 New and existing budget holders will be provided with the appropriate level of training and guidance by a member of the divisional finance team.

3.3 Budget holders can only authorise expenditure within the limits of the recurring funding available.

3.4 Budget holders are responsible for the goods and services for which their budget is delegated.

3.5 It is the budget holder's responsibility to check for accuracy the monthly budget report issued by the divisional finance team. If inaccuracies are found the divisional finance team should be notified.

3.6 It is the budget holder's responsibility to ensure that all new starters, leavers, and changes to existing staff details are correctly processed to ensure budget reports remain accurate and up to date.

3.7 Budget holders should notify the Head of Finance Business Partnering of any potential overspend or unexpected expenditure as soon as they are aware of it.

3.8 Budget holders are responsible for taking corrective action for any overspend and setting out clearly to the Head of Finance Business Partnering what corrective action(s) they are taking and the timescales for implementation.

3.9 Budget holders are responsible for identifying savings schemes or opportunities to use Trust resources more effectively and implementing these to enable the budget they are responsible for and the overall divisional budget to remain balanced or underspent.

3.10 As part of the annual planning process for the IMTP, budget holders, with the support of their finance team, are responsible for:

- producing an activity demand & capacity plan (where appropriate) that is based on the resources available to them within their agreed financial budget;
- Identifying pay inflation, pay increment, other pay pressures and non-pay pressures;
- Identifying unavoidable service cost pressures supported by a full business case that can be presented to commissioners for consideration of funding;
- Identifying prioritised service developments supported by a full business case that can be presented to commissioners for consideration of funding.

4 FINANCIAL STRATEGY

4.1 By February of each year divisional finance staff will meet with all budget holders and agree a provisional budget plan for the following year. These individual budgets will be totalled and compared to the agreed divisional expenditure control limit and an initial budget position discussed between the Head of Finance Business Partnering, the Chief Operating Officer (COO) and Divisional Director. Several iterations of this process may be necessary in order to present a balanced divisional strategy or to include a plan of how each division intends to achieve financial balance. This process will be supported from an early stage by the Finance Director and the Deputy Director of Finance.

4.2 Once approved by the COO and Divisional Director, the financial strategy & plan for each division will be consolidated together with the corporate services financial strategy & plan by the Financial Planning & Reporting Manager, to form the basis of the overall Trust financial strategy & plan. The Deputy Director of Finance will develop the overall Trust three year financial strategy & plan based on the anticipated

additional income the Trust will receive and the consolidated divisional expenditure and savings delivery plans.

4.3 The Finance Director will present the Trust financial strategy & plan, detailing each division's expenditure control limit, assumed income levels, detailed savings plans and any risks & opportunities included in the strategy & plan to the March Trust Board for approval.

4.4 Once the overall financial strategy & plan is approved by the Trust Board all budget holders will be made aware that their provisionally agreed budgets have been accepted and that they are now the agreed budget for the year. These approved budgets will then be reflected in the general ledger on the Oracle financial system.

4.5 Once the overall financial strategy & plan and individual budgets have been agreed by the Board, the Chief Executive, in their role as Accountable Officer for the Trust, will write to the COO, divisional directors and executive directors to formally delegate responsibility for holding and managing their revenue expenditure budgets for the financial year. The Chief Executive may delegate this responsibility to the Director of Finance. This letter will set out:

- the Delegated Expenditure Control Limit* (DECL) each is responsible for (identifying recurring and non-recurring budgets);
- their responsibilities as a budget holder for not exceeding the budget delegation;
- expectations that they ensure at all times propriety and regularity requirements and all other requirements for the maintenance of effective internal financial control are met, and are in accordance with the Trusts Standing Orders and Standing Financial Instructions.
- DECL Letters should be issued no later than the 30th April for the year in which the budget delegation relates.

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**the DECL will reflect the agreed brought forward recurring budget, adjusted for agreed inflationary funding, savings target, service development funding agreed by commissioners and other agreed budgetary adjustments.*

4.6 Budget reports from the general ledger will be issued by divisional finance teams to budget holders on a monthly basis and significant variances must be investigated by the budget holder with identification of corrective action, responsible officer and timescales.

4.7 The Finance Director must be informed of all significant shortfalls in income at the earliest opportunity by either the COO, divisional directors, budget holder or the divisional finance team.

5 BUDGET SETTING

5.1 Following divisional finance staff discussions with individual budget holders, Senior Finance Business Partners and the Head of Finance Business Partnering will prepare and submit a budget plan within the limits of the division's delegated expenditure control limit to the Divisional Management Team for approval in February of each year. As described in the section above, these divisionally approved plans will be consolidated into the overall Trust financial strategy & plan to be approved by the Trust Board in March of each year, prior to the start of the financial year on 1st April. Approved budgets will then be issued to budget holders.

5.2 Budgets will be reviewed annually and will be set with consideration to service reviews and the Trust planning process. Changes to budgets will reflect agreed changes in the level or the way in which services are delivered.

5.3 The accurate phasing of planned expenditure in each budget is key to maintaining in-year financial control. This is the responsibility of the budget holder, supported and advised by the divisional Finance team. The emphasis of management activity is, therefore, focused upon looking forward, controlling planned expenditure, rather than working retrospectively as to why overspending has happened. Each budget has clearly defined phasing representing planned expenditure. This can take many forms, twelve equal monthly payments, month by month specific amounts, quarterly payments, or one single lump sum payment.

5.4 The budgets will be agreed with each delegated budget holder and the Senior Finance Business Partner. In agreeing the budget the following aspects will be discussed and taken into account:

- An assessment of service costs
- Activity levels and forecast demand changes
- Current budget level
- Changes in patterns of service delivery and management
- The overall financial resources and financial strategy of the Trust
- Service development through the planning process and consistency with the agreed Integrated Medium Term Plan (IMTP)
- Level at which Commissioners fund cost pressures and require savings to be made.

5.5 Budget holders shall not assume any increase in the available recurring funding unless confirmed by the Finance Director. Where the results of budget setting identify a need for additional funds, all efforts should be made in the first instance for this to be met from within the budget holders' recurring funds.

5.6 The Deputy Director of Finance and the Head of Finance Business Partnering will review the budgets prior to the Finance Director submitting to the Board.

5.7 Any changes in budgets may be carried out through a 'virement' with the approval of the finance department.

5.8 Within the overall financial resources each division will hold appropriate reserves for specific activities to be released to budgets as appropriate.

5.9 In addition the Chief Executive may also hold reserves for unexpected cost pressures and contingencies and release to budgets as the expense is incurred.

6 BUDGET INFORMATION

6.1 To ensure sufficient relevant and reliable information is available for budget holders, budget reports will be issued monthly for each budget holder by divisional finance teams.

6.2 The monthly budget report will include the following information:

- The total annual budget;
- Details of the actual income and expenditure for the current month;
- Details of the actual income and expenditure for the year to date;
- Individual variances (in month and to date) from the agreed income and expenditure budget;
- Details of the budgeted and actual WTEs together with any variances.

6.3 In addition, each Senior Finance Business Partner will produce a written monthly budget report for the Divisions' senior management team, in a format agreed by the Finance Director, which will be shared with the Finance Director and Deputy Director of Finance. This report will detail:

- A summary of the main issues;
- The financial position to date along with explanations of any significant variances;
- Management actions to correct adverse variances or further exploit favorable variances with identified leads and timescales;
- Analysis of budget changes;
- A summary of the savings delivery performance to date and forecast year end position;
- Details of the division projected end of year position;
- A summary of the key financial risks & opportunities that have not yet crystalised and are not yet reflected in the division forecast outturn position;
- Trend analysis by month of key expenditure areas – actual and variance;
- Recommendations for improving the financial performance.

6.4 Budget values reported in the statements should take into account, wherever possible, all known adjustments to budget and all reasonably anticipated future adjustments. Proportions of budget applied to the report month and the accumulated period to date should take account of appropriate start and finish dates of functions or value variations, seasonal fluctuations, irregular spending

patterns and spending conforming to quarterly, annual (or other non-monthly) patterns.

6.5 Finance staff should carefully assess income/expenditure within each report month and make appropriate accruals in order to account for financial transactions not yet recorded in the accounting records. All accruals must be coded to the correct balance sheet subjective and analysis code.

6.6 After preparation of the statements, the Finance staff will discuss any significant variances displayed in the resulting financial data with budget holders.

7 BUDGET MONITORING & VARIANCE ANALYSIS

7.1 It is important that budget holders review their monthly reports and highlight any variances to the divisional finance team to ensure they are investigated to confirm accuracy and ascertain whether or not they represent a significant trend in expenditure and a potential problem. Variances fall into two categories: overspend and underspend.

OVERSPENDS

7.2 Any overspends should be identified by budget holders at an early stage and immediate action must be taken to rectify the situation, and where possible the budget holder should inform the divisional finance team in advance of any potential overspend. Delay that leads to a loss in opportunity to regulate overspending may be viewed as a serious breach of conduct.

7.3 Expenditure for which no budgetary provision has been made and which cannot be covered by delegated powers of transfer, must not be incurred without the express permission of the Board. The Board have delegated this power to the Chief Executive or Finance Director.

7.4 Where power to transfer between budgets or budget headings has not been delegated, setting an underspending against a corresponding overspending is not permitted.

7.5 Where an overspend is not related to specific factors such as increased workload then budget holders must take immediate corrective action to control their spending within their allocated resources. Where there is an overspend and/or an overspend continues uncorrected then this will be escalated in the Senior Finance Business Partner's written report to the Division's senior management team, the Head of Finance Business Partnering, the COO, the Divisional Director, Finance Director or to the Trust Board.

UNDERSPENDS

7.6 Where there is an underspend, the divisional finance team may vire the funds for use on other expenditure items if appropriate authorisation is given.

7.7 Budget Holders are required to ensure, via their Finance team, that anticipated material underspends, whether planned or otherwise, are notified to the Deputy Director of Finance or Finance Director at the earliest possible opportunity. Failure to make proposals in good time could result in underspend being withdrawn from the Division/Department.

7.8 Underspends arising from:

a) unplanned or fortuitous circumstances;
b) failure to achieve contracted workload or agreed activity;
c) under demand for the budgeted level of service;

should not be used or transferred without the prior agreement of the Chief Executive or Finance Director. Normally, such underspends will be transferred back to a general reserve for re-allocation by the Chief Executive or Finance Director.

7.9 A Budget Holder may not use underspends for other purposes unless specific authority has been given by the Chief Executive or Finance Director either in the notice of delegation of budget or by other means.

VIREMENT BETWEEN BUDGETS

7.10 Divisions/Departments must be able to respond to overspends or underspends if the variations are due to activity and workload, or as a result of external factors influencing expenditure. They, therefore, require defined powers to exercise virement up to a level appropriate to their virement limits as stated below. Virement is defined as a transfer of resources between two budgets, and is in effect a downward revision in one budget off-setting an upward revision in another.

7.11 Divisions/Departments may vire funds between the separate budgets within their control. A Division/Department may ask the Finance Director to reduce a budget limit and raise another budget limit. This facility affords managers some level of flexibility during the year. Controls have been established to ensure that virement only takes place where agreement exists.

7.12 The need for virement is an acknowledgement that the planned budgets need revision, or that someone is seeking to commit expenditure approved by the Board for a certain activity on a different activity. Virement is a serious matter and should not be treated lightly. Authorisation has been delegated only to the Chief Executive or Finance Director.

7.13 The Finance Director has defined appropriate rules for virement between budgets. These rules are based upon an escalating basis of significance of the virement.

The following types of virement will generally not be supported unless a very strong case of need is made by the budget holder:-

- virement between non-recurrent and recurrent resources;
- virement between staff costs and operating expenses;
- virement between capital and revenue.

VIREMENT LIMITS

7.14 Virement below £5,000 is at the discretion of the budget holder and the divisional Finance team.

7.15 Permission for virement between £5,000 and £60,000 has been delegated to the COO and divisional directors, supported by the Head of Finance Business Partnering.

7.16 Virement above £60,000 requires the permission of the Finance Director where staffing budgets are created to ensure that the principles of establishment control are being adhered to, with recurring funds identified prior to permanent appointment.

RESERVES

7.17 The Finance Director, on behalf of the Chief Executive, will endeavour to create such reserves as are deemed necessary to secure the ability of the Trust to meet its financial targets. Reserves may include sums to cover future pay awards, price inflation, unforeseen contingencies, non-recurrent spending and other specific items as yet not allocated to individual budgets.

7.18 The Finance Director may exercise discretion to partly or wholly allocate reserves directly to the Divisions/Departments or subsequent allocation to specific budgets.

BUDGET REVIEW MEETINGS

7.19 A monthly budget review meeting will be held between a member of the divisional finance team and each of the divisions key budget holders to review budgetary performance. As part of these meetings the budget holder is expected to provide detail on:

- actions being taken or planned, with timescales, to correct any material adverse variance;
- actions being taken, with timescales, to recover shortfall on financial savings scheme delivery against savings target;
- any known future financial risks and opportunities and expected crystalisation date that need to be reflected in the year end budgetary performance forecast.

7.20 Quarterly and/or six monthly budgetary performance review meetings will be held between each key budget holder, Head of Finance Business Partnering, Divisional Director or nominated deputy and Deputy Director of Finance. The purpose of these meetings is to:

- enable the division and the finance team to undertake a division wide review of budgetary financial performance;
- review the impact of activity and demand on budgetary performance and what actions need to be taken to ensure planned/contracted activity is delivered within the budgeted resources;
- identify any actions that need to be taken to improve budgetary performance to ensure the divisional service objectives are met;
- identify what corporate support/decisions are required;
- identify any budget virements requiring decision by the Divisional Director or Finance Director;
- discuss any known future financial risks and opportunities and expected crystalisation date that need to be reflected in the year end budgetary performance forecast.

7.21 A monthly meeting will be held between the Deputy Director of Finance, Head of Finance Business Partnering and representatives from divisional finance teams to review budgetary performance on a divisional and overall Trust basis.

7.22 Following the meeting described in point 7.21, a financial position review meeting will take place between the Finance Director and Senior Finance staff to review both the income & expenditure (I&E) position and the balance sheet. This meeting is the basis for the financial report to the Trust Board and the monthly monitoring returns to Welsh Government.

AUDIT COMMITTEE

CHAIRS URGENT ACTION REPORT

DATE OF MEETING	26/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	**CONSIDER** and **RATIFY**.

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

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

EXECUTIVE SUMMARY	Following Audit Action Tracker review and discussion on the outstanding TCS nVCC actions in the April 2023 Audit Committee, the Committee agreed that these could be taken offline and agreed out of Committee.

RECOMMENDATION / ACTIONS	The Committee is asked to **CONSIDER** and **RATIFY** the Chairs urgent actions taken on the 24/05/2023 .

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Audit Committee Members – Via Email	24/05/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Following an Action from the April 2023 Audit Committee on the 24 May 2023, the Audit Committee via email was asked to **APPROVE** the closure of the nine Complete (Green Status) Actions based on the 'Update May 2023'. If agreed these actions will be formally Closed (Blue Status).	

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

APPENDICES	
Appendix 1	Audit Action tracker - 9 Blue Status Update May 2023 Actions

1. SITUATION

The Chair's Urgent Action was sought following an Action from the April 2023 Audit Committee.

2. BACKGROUND

In accordance with Trust Standing Orders, there may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Head of Corporate Governance as appropriate, may deal with the matter on behalf.
Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

3. ASSESSMENT

The Audit Committee was asked to **APPROVE the closure of the nine Complete (Green Status) Actions based on the 'Update May 2023'. If agreed these actions will be formally Closed (Blue Status).**

As with all urgent approval requests, this required formal **APPROVAL** from the **Chair**, and **2 Committee members** as a minimum.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Committee were sent an email on the **24/05/2023** regarding:

Audit Action Tracker and the following Audit Reports:

- **nVCC MIMS Governance 2021/22**
- **nVCC: Enabling Works Final Internal Audit Report**
- **nVCC Development: Contract Management**

The Charitable Funds Committee were asked to **APPROVE:**

The closure of the nine Complete (Green Status) Actions based on the 'Update May 2023'. If agreed these actions will be formally Closed (Blue Status).

The recommendation was **APPROVED** by:

- Martin Veale, Chair of the Audit Committee and Independent Member
- Vicky Morris, Independent Member and Member of the Audit Committee
- Gareth Jones, Independent Member and Member of the Audit Committee

No objections to approval were received.

5. IMPACT ASSESSMENT

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

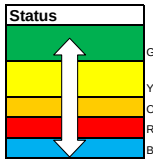
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	N/A
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

6. RISKS

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

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

Audit Action Plan



Priority	
Low	< 3 months *
Medium	< 1 month *
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 for July 2022 Committee	Update March / April 2023	Update May 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	Action Closed			Cycles of business appropriately mapped through internal Trust and joint WG governance.		
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	Action Closed			Cycles of business appropriately mapped through internal Trust and joint WG governance.		

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

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 November 2022	Update December 2022	Update January 2023	Update February 2023	Update March / April 2023	Update May 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 business case 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	Action Closed			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.			All regular reports indicated now received by Project Board - with appropriate reporting into Strategic Capital Board and TCS Scrutiny Sub-Committee.		
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	Action Closed			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.			Business Case development and approval appropriately mapped through internal governance structures.		
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	Action Closed			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.			Reporting on Gateway actions appropriately mapped through internal governance structures		
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	Action Closed			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.			PID completed.		
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	Action Closed			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.			Full risk and issue register for Projects 1,2 and dependencies between all projects managed appropriately through project governance.		
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	Action Closed			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.			Reporting appropriately to Audit Committee.		

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

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	Update May 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	Action Closed			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 Baord 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	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	Action Closed			A Scheme of delegation for major capital projects has been developed which was presented to EMB Shape on 20.03.23 and endorsd for review by the Audit Committee at the 23.04.23 meeting for Board aproval 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	Action Closed				Action closed - approach agreed with Ims in March round of approvals		
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 focus on the MIM Priorities, this has not yet been progressed. Noting wider contract management issues identified at this year's audit, the appointment process should now be considered in conjunction with the new recommendation made. **Conclusion:** Superseded. See **MA1, Appendix A.**	David Powell, Project Director			Action Closed						
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:** Superseded. **See MA1, Appendix A.**	David Powell, Project Director			Action Closed						
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			Action Closed						

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

AUDIT COMMITTEE

PROCUREMENT COMPLIANCE REPORT
11th April 2023 – 23rd June 2023
(Reporting Period)

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Wyn Jones, Deputy Head of National Sourcing Julie Winterburn, Senior Procurement Business Manager
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 11th April 2023 – 23rd June 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	0
11.13	Single Quotation Application or Single Tender Application	Single Tender Actions	2
11.13	Single Quotation Application or Single Tender Application	Single Tenders for consideration following a call for an OJEU Competition	0
11.17	Extending and Varying Contracts	Contract Extensions and Contract Change Note (CCN) or Variation of Terms	0
10.4	Departures from SFIs	Award of additional funding outside the terms of the contract (File notes)	7

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Compliance Assurance (Appendix 1.1)

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

	VCC & Corporate	WBS	Total	Repeat Submission
SQA's	0	0	0	0
STA's	1	1	2	1
Total	**1**	**1**	**2**	**1**

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 11th April 2023 – 23rd June 2023.

Single Quotation Action (SQA) Requests

As part of the strategy to reduce the number of STA/STA's, there are no SQA's to report this period, any requests received were discussed with the service and another route to market sourced, i.e. direct award via framework or quotation exercise via the Multiquote portal.

VCC / Corporate (SQA's)

No SQA's were submitted/approved for this period.

WBS (SQA's)

No SQA's were submitted/approved for this period

Single Tender Action (STA) Requests

For the same period, 1 STA's was submitted/considered appropriate and approved as follows:

VCC / Corporate (1 x STA)

1 x Provision of Ducting and Infrastructure access permissions for Enabling Works Project to undertake connectivity to Openreach Network (diverse resilient feed) to the nVCC MIM site for the Enabling Works Project.

WBS (1 x STA)

1 x Purchase of Factor 8Y Unlicensed medicines

Publication of Contract Awards

In accordance with procurement regulations contract award notices have been published for all contracts awarded above £25,000. There is no guarantee that there will be no risk of challenge from market providers, regardless of the approach adopted from the Public Procurement Regulations 2015.

There are however no associated, perceived or anticipated risks resulting from these award notices and no challenge have been made to date.

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

As part of the NWSSP Integrated Partnership the Velindre Frontline Procurement team has been relocated to the Cardiff and Vale University Frontline Procurement teams base at Woodland House in Cardiff, we are in the process of reviewing the aggregated expenditure and undertaking a more focused approach in inviting competitive quotations. Previously departments were asked to obtain three quotations directly, we have since requested that they engage with Procurement Services who will undertake the relevant route to market.

2.2 Other Matters of Interest

`

Trust Board Approvals Process – Update

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

3 IMPACT ASSESSMENT

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.

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)
Mark Ash / David Powell	Velindre Cancer Centre	VEL-STA-(23-24) 46	July 2023 – September 2023	Single Tender Action	Enabling Works Ducting and Infrastructure access permissions	BT Openreach	£93,933.59	BT Openreach is a statutory authority for the telecommunications network ducts and poles across the UK.	Endorsed	None – Capital Procurement	First Submission
Alan Prosser	Welsh Blood Service	2324/001/WBS	15-May 2023 – 14th May 2024	Single Tender Action	Purchase of Factor 8Y Unlicensed Medicines	Bio Products 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 removed from the Agreement.	Repeat – previous ref WBS-STA-1003

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – July 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
Mark Ash	New Velindre Cancer Centre	VEL-FN-021	1st November 2022 – 31st March 2023	File Note	Provision of architectural consultant (Tier 1) support for the nVCC projects	John Cooper Architects Ltd	£50,000.00	A retrospective file note completed. This additional value is to ensure continuity of service, avoiding further delay to the nVCC project will affect achieving financial close and the opening of the new Velindre Hospital	Competition not sought in accordance with SFI'S	The Trust has completed the procurement process and awarded new contract to John Cooper from April 2023.	Repeat Submission – last reported April 23
Ellie Tipples/Helen Huntley	Velindre Cancer Centre	VEL-FN-023	One-Off Purchase	File Note	Engineer Breakdown Visit & Associated parts	Xstrahl Ltd	£6,229.60	Retrospective requirement for emergency engineering visit to the Medical Physics department	Competition not sought in accordance with SFI'S	Procurement to seek longer term agreement	Repeat Submission – last reported October 2022 – Total cost to date = £19,523
Paul Murphy	Velindre Cancer Centre	VEL-FN-024	01-Oct 21 – 30-Sep-24	File Note	Hire of Radio Systems	Commercial Radio	£14,898.00	Retrospective long-term contract signed off by service	Competition not sought in accordance with SFI'S	Long term strategy to be discussed with service and tender exercise to be undertaken	First Submission
Kylie McKee	Velindre Cancer Centre	VEL-FN-025	24-Jul-23 – 27-Jul-23	File Note	Overseas Bike Ride – 2024 – Cardiff to Paris	Passion in Events	£63,200.00	The supplier was procured directly without procurement involvement by a patient who is fundraising to raise money for Velindre Cancer Centre - Out of Committee request was sought and approved	Competition not sought in accordance with SFI'S	No further actions	First Submission
Kylie McKee	Velindre Cancer Centre	VEL-FN-026	01-Sep-23 – 31-Sep-23	File Note	Overseas Bike Ride – World Cup Ride	White Rock Ltd	£12,875.00	STA Value breached	Competition not sought in accordance with SFI'S	No further actions	First Submission
Mark Ash	New Velindre Cancer Centre	VEL-FN-027	12-Jun-23 – until completion of works	File Note	Asda Coryton – Phase 1 Construction – Installation of Water Main	DWR Cymru Welsh Water	£180,97.56	Exception due to being the only supplier 'This is utilities work and DCWW are the statutory authority and owner of the 24inch water main that serves Cardiff. (Not a breach but procurement were not informed prior to requisition being raised)	Competition not sought in accordance with SFI'S	No further actions	First Submission
Mark Ash	New Velindre Cancer Centre	VEL-FN-028	31-Mar-23 – 01-Sep-23	File Note	Retrospective Provision of equipment related support and advice in relation to nVCC Projects Preferred	Peter Brown Project Management (Wales) Ltd	£12,825.00	Incumbent supplier, established knowledge for essential delivery of the requirement consultancy input, this additional file note is	Competition not sought in accordance with SFI'S	No further actions	Repeat Submission – Previous File Notes completed FN 144 & 007

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
					Bidder stage activities			required for the remainder of the service			

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Velindre University NHS Trust

Velindre University NHS Trust - Audit Committee Report – April 2023 – June 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.	Cleaning & Janitorial Products (NPS Framework)	ratification	£ 3,145,833	11/04/2023	N/A - NPS Framework	21/04/2023	24/04/2023
2.	Prosthetic Components & Associated products This contract covers a wide range of Prosthetic Components and Associated Products such as Integrated Limb Systems, Shoulder Joints, Microprocessor Knees, and Residual Limb Compression Garments. NWSSP-PS worked in collaboration with the Artificial Limb and Appliance Service (ALAS), who manage the Prosthetic service in NHS Wales	extension	£ 10,560,880	30/03/2023	original approval applies 17/5/21	04/04/2023	04/04/2023
3.	Ambient Groceries includes a range of dry and tinned products including flours, sugar, tinned fruit and vegetables, dried pasta and rice, hot beverages and other dry ingredients	ratification	£ 14,843,109	05/04/2023	12/04/2023	04/05/2023	04/05/2023
4.	Whole Blood and Ancillary Collection systems Blood Collection systems (packs used in the collection and manufacturing process) are business critical consumables used to collect blood from donors and produce blood components for use	briefing	£ 3,000,000	05/04/2023	N/A Direct Award from Framework	n/a	n/a
5.	All Wales Taxi and Light Goods Transportation Services – South & West Wales The service requirements are the conveyance of staff, patients, light goods, and medical/pathological specimens and other items, to or from either their place of residence to locations within these Health Board & Trust sites or to other NHS locations. This is on a routine and an ad hoc basis.	briefing	£ 16,000,000	27/04/2023	26/05/2023	n/a	n/a
6.	PTP Education and Training Services HEIW Practitioner Training Programme Part Time Education for Clinical Engineering, Audiology and Life Sciences	briefing	£ 9,874,418	20/04/2023	17/05/2023	n/a	n/a
7.	Clinical Waste sharps Containers NMD-DCO-52537 provision of Bins for Sharps, Cytotoxic, Limb & Placenta Waste	ratification	£ 5,163,817	12/04/2023	N/A Direct Award from Framework	14/04/2023	17/04/2023
8.	Contrast Media The different products will have different licensed indications for use in various therapy areas for example there are specific X-ray media for use within cardiac investigations.	briefing	£ 12,329,124	18/04/2023	03/05/2023	n/a	n/a
9.	Nurses Uniform Contract for the supply of Nurses and Other Healthcare Professionals Uniform all NHS Wales Health Boards and Trusts.	ratification	£ 4,767,545.23 (Global) £ 7,355,682.38 (Blended)	18/04/2023	01/06/2023	07/06/2023	07/06/2023
10.	Energy supply of electricity and gas to NHS Trusts	ratification	Gas fy 22/23 – £63,634,844 Gas fy 23/24 - £71,076,501 Power fy 22/23 - £57,868,334 Power fy 23/24 - £88,730,862	18/04/2023	N/A CCS Framework - sent to WG for info 19/4	Sent to NF 22/6	
11.	Oral Liquids The contract consists of generic liquids, syrups, solutions, suspensions and powders purchased through Pharmacy Departments	ratification	£ 4,549,452	27/04/2023	07/06/2023	08/06/2023	09/06/2023

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+
12.	Biomass Fuel Woodchip and Wood Pellet fuel biomass is used as a heating fuel by organisations across Wales which have a requirement.	briefing	£ 651,518	28/04/2023	n/a at this stage	n/a	n/a
13.	Maintenance of YSIO X-Pree Digital Radiography Systems Provision of regular servicing, corrective maintenance visits to site and the supply and fitting of replacement parts, including specialist elements for the life of the contract. Full technical and clinical applications support is also provided for the life of the contract	ratification	£ 699,105	05/05/2023	N/A Direct Award from Framework	n/a	n/a
14.	Blood Glucose Briefing Paper Blood glucose monitoring refers to testing the concentration of glucose in the blood to aid in the management of Diabetes types 1 and 2. Similarly, monitoring the presence of ketones in the blood is also important as high levels can result in complications such as Ketoacidosis.	briefing	£ 7,677,000	05/05/2023	sent to WG 05/05	n/a	n/a
15.	All Wales Patient Level Information Costing System (PLICS) The solution provides a patient level costing engine that can be traced back to the detail of the financial ledger. In the current financial climate, it is increasingly important to have reliable service cost information and access to the underpinning, more granular patient level direct and support costs	briefing	£ 1,000,000	05/05/2023	sent to WG 05/05	n/a	n/a
16.	Generic Drugs Tablets & Capsules across a range of therapy areas such as Chemotherapy, Arthritis, Heart Disease and Analgesics.	briefing	£ 24,221,230	05/05/2023	18/05/2023	n/a	n/a
17.	HLA Typing for Welsh Bone Marrow Donor Registry Provide will conduct HLA tissue typing of blood or cheek swab samples of prospective bone marrow volunteer donors. Tissue typing is critical to the matching of a donor with a patient.	ratification	£ 843,950	10/05/2023	09/06/2023	12/06/2023	NA
18.	Lift Maintenance The requirement relates to 464 Lifts, across Wales, the contractor would be required to manage the entire portfolio, supporting the quantity and diverse range of equipment, providing maintenance and servicing of these.	ratification	£ 3,290,046	11/05/2023	N/A Direct Award from Framework	12/05/2023	12/05/2023
19.	Distance part time learning nursing Part-Time Distance Learning Nursing education and training services for the four fields of Nursing, Adult, Child, Mental Health, and Learning Disabilities, to complement the full time equivalent within the Health Professional Education and Training Services	briefing	£ 12,636,000	11/05/2023	sent to WG 11/5	n/a	n/a
20.	Continence Products The contract is for the supply and delivery of disposable and washable (reusable) continence products to Secondary Care and Primary Care patients.	briefing	£ 12,000,000	12/06/2023	sent to WG 12/6	n/a	n/a
21.	Primary Care workforce AW079 The solution will engage with key stakeholders such as performers, providers, practice/contractor managers, body corporate organisations, Welsh Government, Health Education and Improvement Wales (HEIW) and NHS Wales Health Boards and Trusts and there is a requirement for the solution to exchange data with a number of solutions and look up from external sources to validate data	ratification	£ 1,831,648	17/05/2023	sent to WG 17/5		
22.	Wigs are provided to patients who temporarily lose their hair through oncology or haematology treatments and to patients who suffer ongoing hair loss through dermatological conditions such as alopecia.	briefing	£ 693,200	16/05/2023	NA at this stage	n/a	n/a
23.	Ophthalmology consumables A Framework Agreement covering all NHS Wales bodies, for the supply of the following ophthalmology consumables that are used in both surgical and outpatient settings of Ophthalmology: Disposable Ophthalmic	ratification	£ 25,203,137	30/05/2023	sent to WG 5/6		

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+
	Instruments, Reusable Ophthalmic Instruments, Ophthalmic machine specific consumables, Ophthalmic packs and kits, Ophthalmic Rings, Glaucoma Implants & Consumables, Vision Testing & Correction Consumables, Eye Stains, Gases, Oils & Visco, Ophthalmic Consumables, Ophthalmic Cannula and Needles, IOL's & Consumables, Value Based/Innovation Offers						
24.	Orthotics The contract covers a range of Upper Limb orthotic products (such as wrist braces and slings), Lower Limb orthotic products (such as knee braces, hip braces and ankle supports) and Head, Neck and Abdominal orthotic products (such as cervical collars and spinal supports).	briefing	£ 9,816,966	06/06/2023	19/06/2023	n/a	n/a
25.	Laryngoscope blades The contract allows the users to purchase their Laryngoscope blades and handles, combi sets, video laryngoscopes and accessories, stylets, bougies and airway exchange catheters.	ratification	£ 2,127,451	06/06/2023	sent to WG 6/6		
26.	Emergency Department Well-being and Home Safe Service The service offers support for frail older people and vulnerable adults in emergency departments, as well as 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	ratification	£ 2,465,444	07/06/2023	12/06/2023	12/06/2023	sent to TM 12/6
27.	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.	ratification	£ 1,953,405	12/06/2023	19/06/2023	20/06/2023	sent to TM 20/6
28.	TRAC The Once for Wales e-recruitment system (TRAC) provides visibility of the full end-to-end recruitment process to all users allowing for the tracking of applicants, shortlisting, interview, and appointment stages.	briefing	£ 2,831,634	13/06/2023	N/A Direct Award from Framework	n/a	n/a
29.	Urine Meters A Urine Meter is a device that accurately measures urine output. They are commonly found in a surgical and intensive care setting.	ratification	£ 928,325	Query to team 21/06			
30.	Post Registration Pharmacy Programme (HEIW-FTS-47927) the delivery of a training programme for post-registration foundation pharmacists in Wales.	extension	£ 3,146,500	19/06/2023	original approval applies 19/7/22	20/06/2023	sent to TM 20/6
31.	Anti-Infective drugs includes antibacterial and antifungal drugs.	briefing	£ 12,266,565	19/06/2023	sent to WG 19/6		

AUDIT COMMITTEE

INTERNAL AUDIT REPORT: Follow Up of Previous Recommendations

DATE OF MEETING	26th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Emma Rees, Deputy Head of Internal Audit
PRESENTED BY	Emma Rees, Deputy Head of Internal Audit
APPROVED BY	Simon Cookson, Director of Audit & Assurance Matthew Bunce, Director of Finance

EXECUTIVE SUMMARY	The purpose of this report is to present the Follow Up of Previous Recommendations Internal Audit report.

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

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

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
N/a

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	This is a 2022/23 report. For 2023/24 onward, individual Internal Audit reports will be linked to the 7 levels of assurance in the cover paper for each individual report, where applicable.

APPENDICES (included within report document)	
Appendix A	Management Action Plan
Appendix B	Assurance opinion and action plan risk rating

1. SITUATION

The audit was undertaken as part of the agreed 2022/23 Annual Internal Audit Plan.

2. BACKGROUND

The purpose of the audit was to provide assurance that:

- recommendations are implemented in a timely manner and have addressed the identified risk; and
- the Audit Action Tracker (the Tracker) provides complete and accurate updates on progress to the Audit Committee.

3. ASSESSMENT

Follow Up Assurance Opinion

Reasonable

All high priority recommendations implemented and progress on the medium and low priority recommendations.

Low to moderate impact on residual risk exposure until resolved.

Our work covered a sample of 13 recommendations containing 27 actions across six 2021/22 internal audit reports, including high and medium priority recommendations from key governance areas audited during 2021/22.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Good progress has been made on implementing the 13 sampled recommendations. We found:

- nine of the recommendations have been fully implemented; and
- the priority ratings for the remaining four recommendations have been reduced to reflect lowered risk due to action taken.

Key open actions

Previous report and recommendation ref	Previous matter arising	Follow-up status	Direction of travel	Current priority	Summary of open actions
Follow Up					
FPR 1.2	Trust Audit Action Tracker	Partially implemented	↑	Medium	Continued improvement to audit action tracking governance

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	10 - Governance

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	One previous recommendation relating to reporting on Infection Prevention and Control was partially implemented and remained open. The priority rating was reduced from medium to low due to the action taken to date.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Internal Audit reports

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/a for this report
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Internal Audit reports

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

6. RISKS

For this section, we have considered whether:

- *the Internal Audit report is linked to any risks in the Trust Risk Register presented to the most recent Quality, Safety and Performance Committee meeting; and / or*
- *the audit identified any other risks not included within the Trust Risk Register where the Trust may wish to consider whether inclusion in Datix is needed.*

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Increased risk (financial, statutory, clinical, reputational) due to risk of failure to implement internal audit recommendations in a timely manner
WHAT IS THE CURRENT RISK SCORE	Linked to a medium priority recommendation in the report.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Implementation requires continued improvement of EMB ownership and accountability of the Audit Action Tracker
All risks must be evidenced and consistent with those recorded in Datix	

Follow Up: Previous Recommendations

Draft Internal Audit Report

July 2023

Velindre University NHS Trust

Contents

Review reference	VT-2223-14	
Report status	Final	
Fieldwork commencement	03/04/2023	
Fieldwork completion	06/06/2023	
Draft report issued	16/06/2023	
Management response received	14/07/2023	
Final report issued	18/07/2023	
Auditors	Simon Cookson, Director of Audit & Assurance	Emma Rees, Deputy Head of Internal Audit
Executive sign-off	Matthew Bunce, Director of Finance	
Distribution	Lauren Fear, Director of Corporate Governance & Chief of Staff	Executive Management Board
Committee	Audit Committee	

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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Velindre University NHS Trust (the Trust) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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

2022/23 Follow Up of 2021/22 Internal Audit Recommendations

Purpose

To provide Velindre University NHS Trust (the Trust) with assurance that:

- recommendations are implemented in a timely manner and have addressed the identified risk; and
- the Audit Action Tracker (the Tracker) provides complete and accurate updates on progress to the Audit Committee.

The scope of this follow-up review provides assurance against the implementation of the agreed actions from the sampled recommendations from prior years' internal audit reports. It does not provide assurance against the full scope and objectives of the original audits.

Follow-up assurance opinion

Reasonable assurance

Our work covered:

6 2021/22 reports

11 matters arising

13 recommendations

27 actions

We found:

9 implemented recommendations

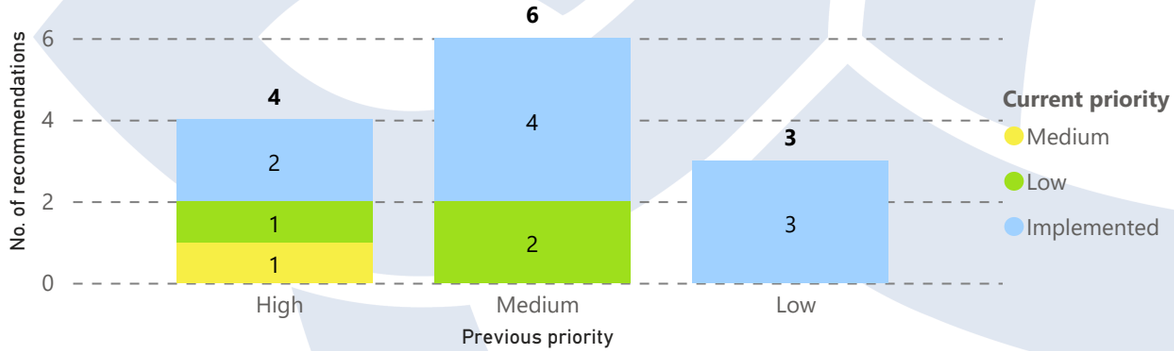
4 partially implemented recommendations

Current priority of open recommendations:

1 medium priority

3 low priority

Prior year recommendations followed up



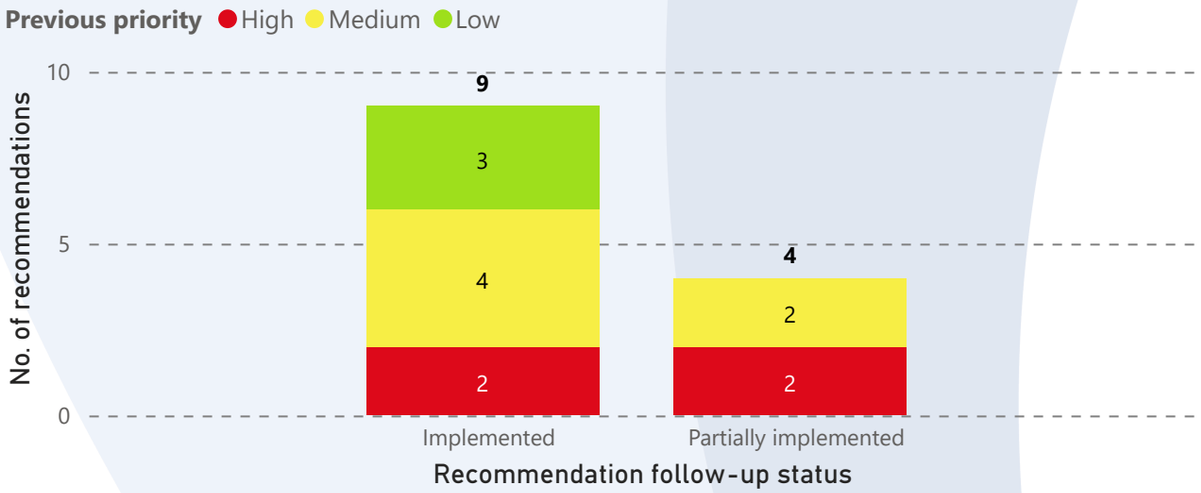
Key open actions

Previous report and recommendation ref	Previous matter arising	Follow-up status	Direction of travel	Current priority	Summary of open actions
Follow Up					
FPR 1.2	Trust Audit Action Tracker	Partially implemented	↑	Medium	Continued improvement to audit action tracking governance

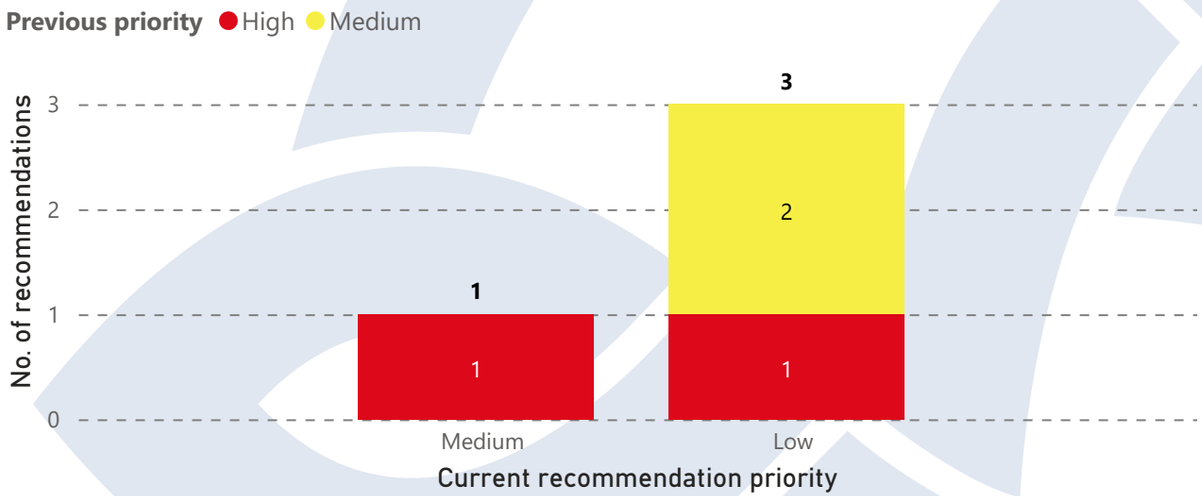
Further detail, including current findings on individual open recommendations, can be found in the 2022/23 Follow Up Dashboard.

Open Actions

Recommendation follow-up status



Open recommendations



Summary of open actions

Previous report and recommendation reference	Previous matter arising	Design / Operation	Previous priority	Recommendation follow-up status	Direction of travel	Current priority	Summary of open actions
Trust Assurance Framework							
TAF 1.1	Completion of the TAF dashboard	Operation	High	Partially implemented	↑	Low	Improving TAF action plans to address control / assurance deficiencies
Board Committee Effectiveness							
BCE 1.1	Cycles of Business and Committee Agendas	Design	Medium	Partially implemented	↑	Low	Cross-referencing the TAF/TRR with the cycles of business to clearly demonstrate links between strategic objectives / risks and committee agendas.
Follow Up							
FPR 1.2	Trust Audit Action Tracker	Design	High	Partially implemented	↑	Medium	Continued improvement to audit action tracking governance
Infection Prevention & Control							
IPC 2.1	IPC Reporting	Design	Medium	Partially implemented	↑	Low	Ensuring VCC uses the agreed IPC report template for upward reporting.

Appendix A: All recommendations followed up

Previous report and recommendation reference	Previous matter arising	Previous priority	Audit Tracker status	Recommendation follow-up status	Current priority	Direction of travel
Trust Assurance Framework						
TAF 1.1	Completion of the TAF dashboard	High	Closed	Partially implemented	Low	↑
TAF 2.1	Operational risk reporting (TRR)	Medium	Closed	Implemented	Implemented	↑
TAF 3.1	Transparency in Decision-making	Medium	Closed	Implemented	Implemented	↑
Board Committee Effectiveness						
BCE 1.1	Cycles of Business and Committee Agendas	Medium	Closed	Partially implemented	Low	↑
BCE 2.1	Benefits Realisation	Medium	Closed	Implemented	Implemented	↑
BCE 5.1	Timeliness of Committee Papers	Low	Closed	Implemented	Implemented	↑
Follow Up						
FPR 1.1	Trust Audit Action Tracker	High	Closed	Implemented	Implemented	↑
FPR 1.2	Trust Audit Action Tracker	High	Closed	Partially implemented	Medium	↑
FPR 1.3	Trust Audit Action Tracker	High	Closed	Implemented	Implemented	↑
Infection Prevention & Control						
IPC 1.1	Policies and Procedures	Medium	Closed	Implemented	Implemented	↑
IPC 2.1	IPC Reporting	Medium	Closed	Partially implemented	Low	↑
DBS Checks						
DBS 3.1	Out of Date Countersignatory	Low	Closed	Implemented	Implemented	↑
Divisional Risk Management						
DRM 1.1	New Risk Management Framework	Low	Closed	Implemented	Implemented	↑

Appendix B: Assurance Opinion and Action Plan Risk Rating 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	Follow up*	Impact on residual risk exposure
Substantial assurance	Few matters require attention and are compliance or advisory in nature	All recommendations implemented and operating as expected.	Low
Reasonable assurance	Some matters require management attention in control design or compliance.	All high priority recommendations implemented and progress on the medium and low priority recommendations.	Low to moderate
Limited assurance	More significant matters require management attention.	No high priority recommendations implemented but progress on most of the medium and low priority recommendations.	Moderate
Unsatisfactory / No assurance	Action is required to address the whole control framework in this area.	No action taken to implement recommendations.	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	N/a

*The scope of a follow-up review provides assurance against the implementation of the agreed actions from the sampled recommendations from prior years' audit reports. It does not provide assurance against the full scope and objectives of the original audits.

Prioritisation of Recommendations

Priority Level	Definition	Potenital impact	Management action
High priority	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 priority	Minor weakness in system design OR limited non-compliance.	Some risk to achievement of a system objective	Within one month**
Low priority	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.

AUDIT COMMITTEE

INTERNAL AUDIT REPORT: Trust Priorities

DATE OF MEETING	26th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Emma Rees, Deputy Head of Internal Audit
PRESENTED BY	Emma Rees, Deputy Head of Internal Audit
APPROVED BY	Simon Cookson, Director of Audit & Assurance Carl James, Director of Strategic Transformation, Planning & Digital

EXECUTIVE SUMMARY	The purpose of this report is to present the Trust Priorities Internal Audit report.

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

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

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
N/a

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	This is a 2022/23 report. For 2023/24 onward, individual Internal Audit reports will be linked to the 7 levels of assurance in the cover paper for each individual report, where applicable.

APPENDICES (included within report document)	
Appendix A	Management Action Plan
Appendix B	Assurance opinion and action plan risk rating

1. SITUATION

The audit was undertaken as part of the agreed 2022/23 Annual Internal Audit Plan.

2. BACKGROUND

The purpose of the audit was to provide assurance over the robustness of the Trust's prioritisation exercise and the governance mechanisms over the delivery of priority programmes.

3. ASSESSMENT

Report Assurance Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

We identified that the Trust:

- had appropriate governance mechanisms over the prioritisation exercise;
- there were clear links between the prioritisation process and the Trust strategies and IMTP; and
- adequate overarching reporting and scrutiny arrangements are in place over the delivery of priority programmes.

The Trust acknowledges the high number of priorities for the size of the organisation and the risks this presents and has reflected these risks within the Trust Assurance Framework.

We did not identify any significant matters for reporting, although management should address the following points:

- ensuring the deliverability section (finance & resource) is completed effectively in future years; and
- revisiting the Prioritisation Framework if overarching progress against priority delivery is not meeting milestones as planned.

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	05 - Organisational Change / Strategic Executive Risk' The report may also provide assurance over TAF 09 Future Direction of Travel
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Internal Audit reports

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/a for this report
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Internal Audit reports

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

6. RISKS

For this section, we have considered whether:

- *the Internal Audit report is linked to any risks in the Trust Risk Register presented to the most recent Quality, Safety and Performance Committee meeting; and / or*
- *the audit identified any other risks not included within the Trust Risk Register where the Trust may wish to consider whether inclusion in Datix is needed.*

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Potential risk of: • non-delivery or poor-quality delivery of priority programmes; • negative impact on: − oversight and delivery of day-to-day activities; − safety / quality of patient / donor care; − staff wellbeing and morale; and − staff retention.
WHAT IS THE CURRENT RISK SCORE	Linked to two medium priority recommendations in the report.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The recommended actions should support risk mitigation to an acceptable level.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	By the identified target completion date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	None identified during the audit
All risks must be evidenced and consistent with those recorded in Datix	

Trust Priorities
Final Internal Audit Report
July 2023

Velindre University NHS Trust

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Contents

Review reference:	VT-2223-07
Report status:	Final
Fieldwork commencement:	19th May 2023
Fieldwork completion:	6th July 2023
Debrief meeting:	29th June 2023
Draft report issued:	11th July 2023
Management response received:	19th July 2023
Final report issued:	19th July 2023
Auditors:	Simon Cookson, Director of Audit & Assurance Emma Rees, Deputy Head of Internal Audit
Executive sign-off:	Carl James, Executive Director of Strategic Transformation, Planning & Digital
Distribution:	Lauren Fear, Director of Corporate Governance & Chief of Staff Matthew Bunce, Executive Director of Finance Philip Hodson, Deputy Executive Director of Planning & Performance Emma Stephens, Head of Corporate Governance Executive Management Board
Committee:	Audit Committee

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

Acknowledgement

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

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Velindre University NHS Trust (the Trust) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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

Executive Summary

Purpose

To provide assurance over the robustness of the Trust's prioritisation exercise and the governance mechanisms over the delivery of priority programmes.

Overview

We identified that the Trust:

- had appropriate governance mechanisms over the prioritisation exercise;
- there were clear links between the prioritisation process and the Trust strategies and IMTP; and
- adequate overarching reporting and scrutiny arrangements are in place over the delivery of priority programmes.

The Trust acknowledges the high number of priorities for the size of the organisation and the risks this presents and has reflected these risks within the Trust Assurance Framework.

We did not identify any significant matters for reporting, although management should address the following points:

- ensuring the deliverability section (finance & resource) is completed effectively in future years; and
- revisiting the Prioritisation Framework if overarching progress against priority delivery is not meeting milestones as planned.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Audit Objectives	Assurance
1	Governance mechanisms over the prioritisation exercise	Substantial
2	Linkage with Trust strategies and IMTP	Substantial
3	Consideration of resource and financial constraints	Reasonable
4	Overarching reporting and scrutiny arrangements over delivery of priority programmes	Substantial

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

Key Recommendations

		Objective	Control Design or Operation	Recommendation Priority
2.1	Use of the deliverability section (finance & resource) of the Prioritisation Framework	3	Design	Medium
2.2	Revisiting the Prioritisation Framework	3	Design	Medium

1. Introduction

1.1 Velindre University NHS Trust (the Trust) is undergoing a period of strategic, organisational and operational change. This ranges from:

- major capital programmes requiring operational changes to service delivery, e.g., Velindre Futures and aspects of Welsh Blood Service (WBS) Futures; to
- workforce programmes, including the Staff Wellbeing Programme and workforce redesign; and to
- develop, enhance and implement key governance mechanisms, such as the Quality & Safety, Trust Assurance and Performance Management Frameworks.

1.2 To ensure appropriate prioritisation and resource availability, during 2022, the Trust undertook an exercise to clearly identify its priorities to support achievement of the new Trust strategies (approved during 2022). The Trust engaged external organisational health consultants – Q5[1] – to support the process.

1.3 The exercise resulted in a list of 37 priorities to be pursued over the next three years, which were presented to the Board in November 2022. The priorities are included within the Trust's 2023-2026 Integrated Medium-Term Plan (IMTP).

Associated risks

1.4 The risks considered during this review were:

- inability to deliver priority programmes due to inadequate governance structures or insufficient resource;
- failure to deliver the Trust's 2022-2032 strategies or 2023-2026 IMTP;
- key risks stemming from failure to deliver individual priority programmes:
  - poor patient / donor experience or patient / donor harm;
  - poor staff experience and impact on staff wellbeing; and
  - financial or reputational damage.

Limitations of scope

1.5 Whilst we considered how the priorities have been integrated into the Trust's 2023-2026 IMTP, we did not undertake a full audit on the development of the IMTP.

[1] Q5 provides advice on strategy, organisation design, organisation change and implementation, organisation development and culture and sustainability. The firm has worked with several NHS organisations and other public sector bodies across the UK.

2. Detailed Audit Findings

Objective 1: robust governance mechanisms were in place over the prioritisation exercise

Engagement

2.1 Starting in June 2022, engagement took place within the Trust to determine priority programmes for 2023-2026 (figure 1).

2.2 Engagement included individual interviews – conducted by Q5 – with Trust senior leadership to identify the Trust's baseline position on change transformation. This then informed the creation of the Prioritisation Framework.

Figure 1: engagement undertaken

		Independent Members	Executive Management Board*	VCC Senior Leadership Team*	WBS Senior Management Team*	Extended Leadership Team*
Q5 interviews	Jul-22	✓	✓	✓	✓	✓
Board progress updates (e.g., development sessions)	Jun/Sept-22	✓	✓			
EMB Shape	Monthly		✓			✓
Divisional SLT/SMT discussions	Ad hoc			✓	✓	
Strategic Development Committee progress updates	Jul/Oct-22	✓				
Trust Board (approval of priorities)	Nov-22	✓				

** EMB is the Chief Executive, Chief Operating Officer plus eight directors. The Extended Leadership Team (ELT) includes deputy and programme directors. Members of divisional SLT/SMT also often attend EMB meetings, particularly the Divisional Directors.*

Prioritisation Framework

2.3 The Framework approach is to score each programme considering a range of factors aligned to the Trust's ten-year strategy (Destination 2032) and deliverability considerations (i.e., affordability and achievability). Programmes are then ranked in terms of contribution to the Trust's Strategy and deliverability.

2.4 As a strategy / direction setting exercise, the prioritisation process for 2023-2026 was undertaken by EMB during August to October 2022 with engagement from ELT and divisional SLT/SMT.

2.5 Progress on the Q5 work and prioritisation process was regularly reported to, and discussed at, EMB, with updates provided to the Strategic Development Committee. Independent Members were also sighted on the process through the Board Development sessions.

2.6 The final list of priority programmes was approved by the Board in November 2022.

Wider stakeholder engagement

2.7 In future years, the Trust could further enhance the benefits of the Prioritisation Framework by using it in discussions with external stakeholders (e.g., Welsh Government, commissioners, Llais, etc.) during the annual planning process. See matter arising 1 in Appendix A.

Conclusion:

2.8 We did not identify any significant matters for reporting and raised one low priority recommendation for consideration to further enhance the prioritisation process. Therefore, we have provided **substantial assurance** over this audit objective.

Objective 2: Trust priorities are clearly linked to the Trust strategies and IMTP

2.9 The Prioritisation Framework requires programmes to be scored against the Trust's five strategic pillars within the Destination 2032 Strategy. For each pillar, there is a set of factors (e.g., questions, statements, etc) to consider whether the programme contributes to the pillar.

2.10 We verified that:

- the 2023-2026 prioritisation approach was clearly aligned to the Destination 2032 Strategy;
- the approved priority programmes were incorporated into the Trust's 2023-2026 IMTP planning guidance; and
- that approve priority programmes have been incorporated into the Trust's 2023-2026 IMTP.

2.11 To further enhance the process, the Trust could consider extending or tailoring the Prioritisation Framework to incorporate the divisional and enabling strategies to support consistency and robustness in prioritisation and decision-making at all levels within the Trust. See matter arising 1 in Appendix A.

Conclusion:

2.12 We did not identify any significant matters for reporting and raised one low priority recommendation for consideration to further enhance the prioritisation process. Therefore, we have provided **substantial assurance** over this audit objective.

Objective 3: resource and finance constraints have been considered and addressed

2.13 The Prioritisation Framework contains a section to assess the deliverability of priority programmes (i.e., consideration of resource and finance). However, it was not completed for the 2023/24 priorities. We were informed this was due to the Trust already being committed to many of the identified priorities, and that the process undertaken was more akin to a 'test run' on the strategic elements of the Framework to assess its potential for future planning.

2.14 Finance and resource considerations were discussed frequently at EMB Shape meetings throughout the process, and we verified that these had been incorporated into the development of the Strategic Financial Plan for the 2023-2026 IMTP.

2.15 The Financial Plan clearly outlines that the planning assumptions include:

- receipt of additional income from commissioners to cover new service developments they agree to invest in; and

- that prioritised service development will be submitted to commissioners as business cases for funding consideration.

2.16 It also recognises risks and cost pressures relating to the priorities, namely around revenue funding for the Transforming Cancer Services and Velindre Future programmes.

2.17 As part of the prioritisation exercise, the Trust identified which priorities were already in progress / committed and have been included (and therefore funded) in previous IMTPs (22 priorities), and which priorities were new for the 2023-2026 IMTP (16 priorities).

2.18 For the 16 new priorities, we note that the Trust has identified that:

- eleven do not require any additional resource;
- two require resource and funding requests have been submitted to Welsh Government via Business Cases;
- one does not require additional resource for phase 1, but that future phases may require different capabilities (yet to be determined); and
- there are two priorities where additional resource is required but the specific needs have yet to be determined.

2.19 The Trust acknowledges that it has a high number of priorities for the size of the organisation and that:

- finance and resource pressures present a risk to achieving delivery of the programmes; and
- resource availability challenges also present the risk of staff being spread too thinly across priority delivery and day-to-day business activities, potentially resulting in poor quality work (for priorities and / or day-to-day activities) and / or a negative impact on staff wellbeing and morale. This, in turn, could impact on patient / donor safety and staff retention.

2.20 The Trust Assurance Framework addresses the related risks around:

- the level of organisational change across the organisation (e.g., uncertainty and complexity, disruption to day-to-day activities, adverse impact on staff, etc) – TAF 05; and
- the potential impact of not having the right staff in place on the transformational ambitions – TAF 03.

2.21 As part of the commissioned work, Q5 explored and recommended a range of delivery options to support transformational change within the Trust. Q5 identified:

- where change resource currently sits within the divisions / corporate functions;
- key capabilities for organisational change, highlighting capability gaps within the Trust; and
- provided different options for an effective structure for the delivery of transformational change.

2.22 We were informed that, whilst some staff have moved between programmes (mainly due to the transfer of some projects from the TCS programme to Velindre Futures), formal consideration of the structural options for change delivery has yet to take place. As stated in the Finance Plan, the Trust recognises that resourcing decisions and investment in organisational capacity and capability are required to deliver its major change programmes.

2.23 Going forward, there would be benefit in using the deliverability section of the Framework as part of the annual planning process, alongside the existing financial planning approach, as this could enhance the overview on the deliverability of Trust priorities as a whole, rather than potentially considering priorities on a more granular basis.

2.24 Given the number of priorities and the risks associated with finance and resource constraints, we also recommend that the Trust revisits the Prioritisation Framework, including completion of the deliverability section, if overarching progress against priority delivery is not meeting identified milestones as planned.

2.25 See matter arising 2 in Appendix A.

Conclusion:

2.26 We identified two medium priority recommendations relating to strengthening existing financial planning / decision-making and ensuring deliverability of identified priorities. Therefore, we have provided **reasonable assurance** over this audit objective.

Objective 4: robust reporting arrangements have been determined to provide overarching scrutiny and accountability over priority delivery

2.27 Overarching scrutiny and accountability over priority delivery will take place through the reporting process for the IMTP. Quarterly progress reports against IMTP objectives are taken the divisional SLT/SMT, EMB Run and the Quality, Safety & Performance Committee (QSP).

2.28 IMTP reporting for Q1 2023/24 had just started at the time of our fieldwork (June-July 2023), so we verified that the Q1 report had been taken to the late-June EMB Run meeting. It is on the agenda for the July QSP meeting (after this report will be finalised).

2.29 Additionally, we note that:

- Q5 recommended revised governance and accountability arrangements for major programmes Transforming Cancer Services, Velindre Futures and WBS Futures; and
- the Building our Futures Together PID sets out the governance and accountability mechanisms for this programme.

2.30 Together, these major programmes account for 27 of the 37 Trust priorities.

2.31 Whilst these revised / new governance mechanisms are not yet formally in place / reporting, we reviewed the proposed structures and found they had been designed

to provide appropriate governance and accountability mechanisms over the delivery of the related priorities.

Conclusion:

2.32 We did not identify any matters for reporting. Therefore, we have provided **substantial assurance** over this audit objective.

Appendix A: Management Action Plan

Matter Arising 1: Enhancements to the prioritisation process (Design)	Impact
We identified recommendations for consideration to enhance the benefits of the Prioritisation Framework approach.	Potential risk of not maximising the benefits of the Prioritisation Framework approach.

Recommendations	Priority
1.1 The Trust could further enhance the benefits of the Prioritisation Framework by using it in discussions with external stakeholders (e.g., Welsh Government, commissioners, Llais, etc.) during the annual planning process.	**Low**
1.2 The Trust could consider extending or tailoring the Prioritisation Framework to incorporate the divisional and enabling strategies to support consistency and robustness in prioritisation and decision-making at all levels within the Trust.	**Low**

Agreed Management Action	Target Date	Responsible Officer
1.1 Agreed - The Trust is currently developing its engagement plan of the development of our plan during 2023/24. This will include a process for clearly articulating our key organisational priorities (output of the prioritisation framework) to both our internal and external stakeholders.	29/09/2023	Executive Director of Strategic Transformation, Planning & Digital
1.2 Agreed – The Trust will review how the prioritisation framework and supporting methodology could be used to support other areas of service development. As part of this work, we will consider if it should be used to support prioritisation in divisional and enabling strategies.	31/10/2023	Executive Director of Strategic Transformation, Planning & Digital

Matter Arising 2: Risks to delivery – finance and resourcing (Design)	Impact
Whilst finance and resource for the Trust priorities was considered during the 2023/24 IMTP planning process and incorporated into the Financial Plan, the deliverability section of the Prioritisation Framework (relating to finance and resources) was not completed for the 2023/24 prioritisation process. We were informed this was due to the Trust already being committed to many of the identified priorities, and that the process undertaken was more akin to a 'test run' on the strategic elements of the Framework to assess its potential for future planning. The Trust acknowledges that it has a high number of priorities for the size of the organisation and that: • finance and resource pressures present a risk to achieving delivery of the programmes; and • resource availability challenges also present the risk of staff being spread too thinly across priority delivery and day-to-day business activities.	Potential risk of: • non-delivery or poor-quality delivery of priority programmes; • negative impact on: – oversight and delivery of day-to-day activities; – safety / quality of patient / donor care; – staff wellbeing and morale; and – staff retention.

Recommendations	Priority
2.1 The Trust should use the deliverability section of the Framework as part of the annual planning process, alongside the existing financial planning approach to enhance the overview on the deliverability of Trust priorities as a whole, rather than potentially considering priorities on a more granular basis.	**Medium**
2.2 The Trust should revisit the Prioritisation Framework, including completion of the deliverability section, if overarching progress against priority delivery is not meeting identified milestones as planned	**Medium**

Agreed Management Action	Target Date	Responsible Officer
2.1 Agreed - The Trust will use the deliverability section of the Framework to support the development of our plan for 2023/24.	31/10/2023	Executive Director of Strategic Transformation, Planning & Digital
2.2 Agreed - The Trust will revisit the Prioritisation Framework at the end of the financial year, including completion of the deliverability section, if overarching progress against priority delivery is not meeting identified milestones as planned.	31/03/2024	Executive Director of Strategic Transformation, Planning & Digital

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

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

AUDIT COMMITTEE

COMMITTEE CYCLE OF BUSINESS 2023/2024

DATE OF MEETING	26/07/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff and Alison Hedges, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	It is good practice for all Board / Committees to have in place an agreed Cycle of Business for the forthcoming year.
RECOMMENDATION / ACTIONS	The Committee are asked to **note** the contents of the attached Cycle of Business plan for 2023/2024.

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

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

APPENDICES	
Appendix 1	Audit Committee annual plan 2023 2024 Draft

1. SITUATION

It is good practice for all Board / Committees to have in place an agreed Cycle of Business for the forthcoming year.

2. BACKGROUND

The attached draft Cycle of Business aims to provide the Committee with the basis on which it will monitor its progress during the year.

3. ASSESSMENT

The attached draft Cycle of Business provides clarity to those who contribute to the agenda and sets out expectations for the coming year.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Audit Committee is asked to note the contents of the attached Cycle of Business plan for 2023/24.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☐ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐

	• The plan is prepared in line with the structure for the Committee agenda. • It will ensure that ongoing agendas are easy to manage and monitor. • Provides a structured presentation to enable obvious gaps to be highlighted.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	N/A
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this in relation to the Cycle of Business.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

6. RISKS

There are no risks associated with any matters addressed in the report.

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

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Audit Committee Cycle of Business July 2023- July 2024

Item	Frequency	July 2023 Endorsement of Accounts and Audit Committee	Oct 2023	December 2023	March 2024	June 2024 Endorsement of Accounts	July 2024
External Audit							
Approval of Annual Outline of Audit Work	Annually	n/a	n/a	n/a	✓	n/a	n/a
Progress Reports	All regular meetings	✓	✓	✓	✓	n/a	✓
ISA 260 and Accounts Opinion	Annually	✓	n/a	n/a	n/a	✓	n/a
Final Accounts Report/Management Letter	Annually	n/a	✓	n/a	n/a	n/a	n/a
Receipt of Annual Audit Report	Annually	n/a	n/a	n/a	✓	n/a	n/a
Internal Audit							
Approval of Annual Plan	Annually	n/a	n/a	n/a	✓	n/a	n/a
Progress Reports	All regular meetings	✓	✓	✓	✓	n/a	✓
Receipt of Annual Report	Annually	✓	n/a	n/a	n/a	✓	n/a
Receipt of Individual Reports	All regular meetings	✓	✓	✓	✓	n/a	✓
Clinical Audit Annual Plan	Annually	n/a	n/a	n/a	✓	n/a	n/a
Clinical Audit Annual Report	Annually	✓	n/a	n/a	n/a	n/a	✓
Counter Fraud							
Approval of Annual Plan	Annually	n/a	n/a	n/a	✓	n/a	n/a
Progress Report	All regular meetings	✓	✓	✓	✓	n/a	✓
Receipt of Annual Report	Annually	n/a	n/a	n/a	✓	n/a	n/a
Administration							
Agreement of Committee Cycle of Business	Annually	✓	n/a	n/a	n/a	n/a	✓
Committee Effectiveness Survey Issued	Annually	n/a	✓	n/a	n/a	n/a	n/a
Committee Effectiveness Survey Report	Annually	n/a	n/a	✓	n/a	n/a	n/a
Production of Audit Committee Annual Report	Annually	n/a	n/a	✓	n/a	n/a	n/a
Review of Audit Committee Terms of Reference	Annually	n/a	n/a	✓	n/a	n/a	n/a
Assurance Development and Risk Management Developments							
Review of Standing Orders, SFIs and Scheme of Delegation	Annually	n/a	n/a	✓	n/a	n/a	n/a
Review Trust Risk and Assurance Frameworks *Frequency to be reviewed following embedding of the new frameworks	All regular meetings	✓	✓	✓	✓	n/a	✓
Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria	Every other meeting	n/a	✓	n/a	✓	n/a	n/a
Losses and Special Payments report	All regular meetings	✓	✓	✓	✓	n/a	✓
Approval of Governance Statement	Annually	✓	n/a	n/a	n/a	✓	n/a
Report of Procurement Activity	All regular meetings	✓	✓	✓	✓	n/a	✓
To receive audit action plan update	All regular meetings	✓	✓	✓	✓	n/a	✓
Review of all outstanding audit actions from Internal & External Audit	Semiannually	n/a	✓	n/a	✓	n/a	n/a
Legislative & Regulatory Compliance Register	Every other meeting	n/a	✓	n/a	✓	n/a	✓
Clinical Audit Report & Clinical Audit Plan	All regular meetings	✓	✓	✓	✓	n/a	✓
The CSQR Programme / medical workforce planning update report	Annually	n/a	✓	n/a	n/a	n/a	n/a
Finance							
Review of Accounting Policies	Annually	✓	n/a	n/a	n/a	✓	n/a
Endorsement of Annual Accounts	Annually	✓	n/a	n/a	n/a	✓	n/a
Receipt of Finance Technical updates	All regular meetings	✓	✓	✓	✓	n/a	✓
Private Patient Service Financial Controls Review	All regular meetings	✓	✓	✓	✓	n/a	✓