Bundle Strategic Development Committee 7 July 2022

1.0.0 STANDARD BUSINESS

1.1.0 Welcome & Introductions

Led by Chair: Stephen Harries

1.2.0 Apologies for Absence

Led by Chair: Stephen Harries, Independent Member

1.3.0 Declarations of Interest

Led by Chair: Stephen Harries, Independent Member

2.0.0 CONSENT FOR APPROVAL

2.1.0 Minutes of the Committee Meeting held on 16th May 2022

Led by Chair: Stephen Harries, Independent Member

2.1 PUBLIC SDC 160522 Minutes - LF - SH.docx

2.2.0 Action Log

Led by Chair: Stephen Harries, Independent Member

2.2 PUBLIC - Strategic Development Committee Action Log 16.05.22-LF.docx

3.0.0 ITEMS FOR REVIEW/DISCUSSION

3.1.0 Welsh Blood Service Five Year Plan

Led by Alan Prosser, Director, WBS
Endorse for Trust Board approval

3.1 SDC Cover Paper WBS Strategy Jul22.docx

3.1 WBS 5 Year Strategy - Update Jun22.ppt

3.2.0 Performance Management Framework

Led by Carl James, Director of Strategic Transformation, Planning and Digital
Endorse for Trust Board approval

3.2 SDC - Performance Management Framework - 7th July 2022.docx cj final.docx

3.2 Annex A - Performance Management Framework -SDC Cttee - 7.7.22 - final.pptx

3.3.0 Plasma Memorandum of Understanding

Led by Alan Prosser, Director, WBS
For noting

3.3 FINAL public SDC July 2022 Plasma MOU v2.docx

3.4.0 Update on progress of the Advanced Therapies Wales & Midlands and Wales ATTC Programmes

Led by Cath O'Brien, Chief Operating Officer and Mark Briggs, Assistant Director of Innovation
For noting

3.4 ATW SBAR SDC June 2022 FINAL.docx

3.4 MW-ATTC SBAR SDC June 2022 FINAL.docx

3.4 APP MW-ATTC Brochure.pdf

3.5.0 Trust Assurance Framework

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

3.5 TAF SDC Final Paper - 07.07.22-LF.docx

3.5 V6 TAF DASHBOARD - UPDATED 01.07.2022.pdf

3.6.0 Nuffield Trust Progress Report

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

3.6 SDC - Nuffield Trust Recommendations Progress - 7th July 2022.docx

3.7.0 University Status Showcase Event

Led by Lauren Fear, Director of Corporate Governance & Chief of Staff and Jacinta Abraham, Executive Medical Director
For discussion

3.7 University Designation Status and Workshop- SDC Update.docx

3.7 Appendix 1 - University Health Board Showcase Cancer Research Development Ambitions 2021-31 - CCRH Case Study - Narrative.docx

3.7 Appendix 2 - University Health Board Showcase CDRL - Narrative.docx

4.0.0 ANY OTHER BUSINESS

Prior agreement by the Chair required
Led by Chair: Stephen Harries, Independent Member

5.0.0 REVIEW OF THE MEETING

Led by Chair: Stephen Harries, Independent Member

6.0.0 DATE AND TIME OF NEXT MEETING

Thursday 13th October @ 10.00am
Via Microsoft Teams

7.0.0 CLOSE

Strategic Development Committee
Public Session

MINUTES OF THE MEETING
Held on 16th May 2022 @ 9:30-11.00am
Trust Headquarters, Nantgarw
(via Teams)

Chair:		
Stephen Harries	Vice-Chair, Independent Member	SHarries
Members:		
Gareth Jones	Independent Member	GJ
Andrew Westwell	Independent Member	AW
Prof Donna Mead	Chair	DM
In Attendance:		
Steve Ham	Chief Executive Officer	SHam
Carl James	Director of Strategic Transformation, Planning & Digital	CJ
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Dr Jacinta Abraham	Executive Medical Director	JA
Philip Hodson	Deputy Director of Planning & Performance	PH
Peter Gorin	Head of Corporate Planning & Performance	PG
Alan Prosser	Director of Welsh Blood Service	AP
Matthew Bunce	Executive Director of Finance	MB
Cath O'Brien	Chief Operating Officer	COB
Suzanne Rodgers	Head of Digital Programmes	SR
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Scientists	NW
Krisztina Kozlovszky	Principal Auditor, Audit & Assurance Services, NWSSP	KK
Rachel Hennessy	Interim General Services Manager, WBS	RH
Susan Thomas	Deputy Director of Organisational Development & Workforce	ST
Liane Webber	Business Support Officer/Secretariat	LW

1.0.0	STANDARD BUSINESS	ACTION

1.1.0 Welcome & Introductions

Alan Prosser was welcomed to his first meeting since his appointment to the role of Director of the Welsh Blood Service.

1.2.0 Apologies for Absence

Apologies were received from:

- Hilary Jones
- David Powell
- Martin Veale
- Sarah Morley
- Katrina Febry
- Emma Rees

1.3.0 Declarations of Interest

There were no declarations of interest.

2.0.0 CONSENT FOR APPROVAL

2.1.0 Minutes of the Committee Meeting held on 23rd March 2022

The Committee **approved** the minutes of the meeting held on 23rd March 2022.

2.2.0 Action Log

Ref 4.1.0 – It was suggested that this action should not be closed. Noted that CJ has suggested writing to the regional partnership boards as an organisation to understand what is on their individual agendas, to give a sense of where we can add the most value. Agreed to reopen the action for further discussion at Board Development and set the target date as 7th July 2022 (next SDC meeting).

The Committee **approved** the updated action log and the updates provided.

3.0.0 ITEMS FOR REVIEW/DISCUSSION

3.1.0 Enabling Strategies

CJ outlined the Sustainability Strategy and brought the Committee's attention to the section entitled "What we want to achieve", highlighting in particular the intention to become a net zero organisation by 2030. RH queried the ability to achieve net zero within the expected timeframe given the various macro level challenges. CJ highlighted that NHS Wales are to reach net zero, but it was accepted that not all parts of the organisation would be able to meet this target immediately as some elements are harder to achieve, but that it was important to set an ambitious target.

DM highlighted the works undertaken at Swansea Bay and noted that the electricity at Morriston Hospital is now provided solely via solar panels, with large annual savings as a result. DM acknowledged that all of the plans outlined in the strategy, when combined, would have an effect on reducing emissions but queried whether anything as large-scale as that at Morriston was planned. CJ reported that the largest saving would be due to the new infrastructure – nVCC is expected to be the first all-electric hospital in the UK. Also noted the importance of societal transformation and the need to develop a plan to deliver education for sustainability. Noted further that other potential opportunities are currently being explored.

AW stated that although it is broadly evident that all the pillars and enablers are interconnected it would be helpful to find a way to emphasise the fact. AW also highlighted the Digital Strategy and the use of blood donor and cancer patient case studies which he felt enhanced the document. Suggested including similar case studies in other strategies given that they are to become public-facing documents. CJ acknowledged the suggestion and **agreed** that additional case studies would be a welcome inclusion.

SHarries queried the Measurement of Success and raised concern about setting the targets too high, particularly with regards to environment and climate. GJ queried what consequences, political or otherwise, could come about if targets were not met. CJ advised that the strategy is to primarily to signify the direction of travel and may well change as time progresses. Noted that the majority of targets were not statutory/obligatory and not pass/fail in nature but rather more as an indicator of progress. **CJ**

DM addressed the People strategy and whilst supportive of the content, felt that there is a gap – the document reads as a medium to long-term strategy but doesn't address current urgent workforce issues. ST moved to offer assurance and explained that the strategy is to provide strategic intent but agreed that attraction and retention was a key priority. Noted that an active Recruitment and Retention Group has been established to address current key issues.

Re the Estates strategy, DM commended the Estates department for their flexibility and agility which was credited it as a main contributor in successfully navigating the organisation through the pandemic and queried the plan for maintaining that ability of Estates department to have the flexibility and agility to modify as and when is necessary. CJ acknowledged the comments and explained that the challenge is to develop a succession plan, particularly around apprenticeships. Note that a programme has been put in place to address this. CJ brought attention to the introduction of technology in the Estates strategy, from

metering to automation, visualisation and use of AI. Noted also that the refurbished Llantrisant site, brand new cancer facility and brand-new Radiotherapy Satellite Centre will require a different type of skillset. CJ to accentuate this further in the document.

GJ highlighted that in several places it states that we provide services from locations that we *own* when some are in fact leasehold. Suggested to replace *"own"* with *"occupy"* and this was **agreed**. Also noted that Welsh Blood in Dafen states that the lease runs until 2022 but AP reported that the lease has been extended and this amendment will be made.

GJ queried the availability of the Equality Impact Assessments referred to in the cover paper. CJ reported that these are almost complete and will be presented to the Board on 26th May.

Noted several typographical errors, particularly in the Estates Strategy, which need to be amended prior to presenting to the Board. Also noted an error in the People Strategy – foreword – which refers to "Estates excellence". **CJ**

SHarries suggested that to avoid repeated questions when presented to the Board, the cover paper be extended to include the key issues discussed at this Committee. CJ to discuss further with SHam and LF.

The Committee **endorsed** the strategies for Trust Board approval. **AP**

CJ

CJ/ / SHam/LF

3.2.0 Performance Management Framework

CJ outlined the Performance Management Framework and drew the Committees attention to the main principles currently being worked on. GJ requested that in year-to-date trend, hyperlinks be inserted from the scorecards through to the detailed information in Appendix 3 for each of the targets to enable easy navigation. PG confirmed that this was planned. GJ also expressed concern with regards to the increased workload created in handling and processing the data and queried whether this could be automated. COB explained that progress of the BI element will happen due to implementation of the Canisc replacement, although this will likely take several years. CJ agreed that although it is a lengthy process which will take time, it is a crucial aspect of the business which deserves particular attention. CJ added that the key point with regards to the data handling is to generate insight and knowledge.

In terms of presenting the information, COB noted that some of the information is new but is presented alongside primarily existing data. Noted further that as well as looking at the data, cycle of production and scrutiny need to be examined prior to being presented to the Committee, but consultation with members is required to ascertain the necessary targets.

RH queried the term “baseline” in the charts. PG reported that the baselines are yet to be clearly defined but currently representing goal as a starting point. Noted that these figures are displayed in red to indicate that they are currently in development. RH also commented on how some key definitions would be understood by the wider public, but also noted that some of the clearer terms – such as “senior role” – also require further definition (i.e., what do we class as a senior role?). CJ confirmed that the document will be presented alongside a “glossary” of definitions.

GJ requested clarity on the timeline of the PMF reports. COB explained that the initial PMF Report in its basic form containing manual data preparation would be presented in September but that the full version would take longer to complete.

The Committee **discussed and reviewed** the Project Management Framework.

3.3.0 Patient Engagement Strategy

COB outlined the Patient Engagement Strategy and the work undertaken to develop it.

SHarries highlighted a past issue of former patients not feeling fully supported and, whilst acknowledging that much work has been undertaken to address this, queried whether "patients" as referred to in the document included former patients or only patients currently in the system. COB explained that whilst this document refers to current patients, there is an opportunity to engage with former patients who are keen to share their experiences post-treatment and help shape the system for the future.

DM raised the following points:

- Queried the staffing of the Patient Engagement Hub and whether the two new roles outlined in the cover paper are in addition to the current Band 6 or to replace.

- Queried how the Patient Engagement Strategy for the Health Board would dovetail with the same for VCC. COB explained that contact has already been made with the Patient Engagement leads at the Health Boards and work is underway with the network to establish whether what is being done in South East Wales can be extended for cancer patients across Wales. **Agreed** to strengthen this in the document and cover paper.

- Referred to the Our Goals section, in particular no. 5 which reads: "We will signpost our patients, their families and carers to the right information, at the right time" and queried how that would align with the role of Navigators. COB explained that the goal is to review the role of the Navigator and establish any gaps that may exist in order to ensure a single cohesive patient information provision. **COB**

- Research (Goal 6) – queried how the actions align with the role of Principal Investigator and recruitment of patients and their relevant Consultant. COB reported that the Research Team themselves had recognised that there is work to be done in terms of communication and engagement with patients re raising awareness of clinical trial availability and how the Principal Investigators can be supported in this. DM raised concern with some of the language used, specifically "*Ensure* that research and research opportunities are accessible…" and strongly suggested that this was reviewed as this was a responsibility of the Principal Investigator.

- Technology – queried whether anyone be excluded from involvement due to not having access to the appropriate technology. COB reported that this would not be a barrier and would be addressed in terms of Equality and Diversity.

The Committee **endorsed** the Patient Engagement Strategy for Trust Board approval, but **noted** that the delivery will require the appointment of two new posts which will be submitted as an application to the Charitable Funds Committee

3.4.0 Trust Assurance Framework

LF gave a brief outline of the paper and updates made since its previous submission to the Committee.

The Committee **endorsed** the Dashboard for Trust Board approval and **noted** the progress made in terms of continued development.

3.5.0 Nuffield Trust Progress Report

CJ presented the Nuffield Trust Progress Report. SHarries clarified that, although now past, many of the dates set out refer to the date the activity started, and significant progress has since been made.

NW reported on an Unscheduled Care Clinical Summit that is currently being arranged to review the current model of delivery within the cancer service based on the current national unscheduled care pressures.

GJ queried the likelihood of any issues being raised by Welsh Government upon receipt of the report. Whilst noting that it was not possible to accurately predict the outcome, CJ referenced the requirements of Welsh Government and outlined briefly how each point has been addressed. JA stated that progress has been made, in some areas more than anticipated, particularly in terms of the Research Hub, but noted that some of the recommendations require a cultural change for the workforce who are currently under considerable pressure. SHam expressed confidence that the report will be well-received as it addresses many of the points raised by Welsh Government in terms of regional working and reflects a real step-up with partnership working. Noted that this has required an extensive amount of work and energy to get to this point and should be reflected upon.

DM observed that Velindre is taking the leadership role, but the name doesn't appear anywhere in terms of the Cardiff Research Centre. CJ agreed the importance of this.

The Committee **noted** the Nuffield Trust Progress Report.

3.6.0 Developing the South East Wales Cancer System

CJ gave a brief outline of the report, and the following points were raised and addressed:

- Page 2, para 1.3 "The report included the following recommendation which was accepted by the CCLG". CJ explained that this referred to Recommendation 1 in the Nuffield report.
- Page 4 – Priority actions identified, ii reads "Discussions with the Cancer Network to". CJ elaborated as follows:
  1. to ensure we have one approach
  2. to identify some resource to help us pull together on behalf of CCLG

CJ and CJones to amend the paper as highlighted above. **CJ / Carys Jones**

The Committee **noted** the Developing the South East Wales Cancer System report.

3.7.0 Implementation of Hepatitis B Core Antibody Testing

The Committee **noted** the Implementation of Hepatitis B Core Antibody Testing report.

3.8.0 Research, Development & Innovation (RD&I) Highlight Report

AW gave a brief outline of the RD&I Highlight Report. JA noted that as this was their first Highlight Report to this Committee, feedback from the group in terms of future content is welcomed. Agreed that this should be provided by email outside of the meeting. **ALL**

The Committee **noted** the RD&I Highlight report.

4.0.0 ANY OTHER BUSINESS

There we no additional items of business.

5.0.0 REVIEW OF THE MEETING

DM highlighted and welcomed the significant progress that has been made across a number of the processes discussed: The Trust Assurance Framework, Nuffield Report, etc. and acknowledged the extensive amount of work that this has entailed.

SHarries raised the issue of quality control of future Committee papers and requested that, as far as possible, any spelling, grammar and typographical errors are amended prior to distribution.

6.0.0 DATE AND TIME OF NEXT MEETING

Thursday 7th July @ 2.00pm

Via Microsoft Teams

Strategic Development Committee

16th May 2022

Action Summary

Minute Ref.	Action	Assigned to	Meeting Date	Target Date	Progress to date	Status (Open / Closed)
4.1.0	Consideration of Trust role in the Regional Partnership Boards. In the May meeting, CJ suggested writing to the regional partnership boards as an organisation to understand what is on their individual agendas, to give a sense of where we can add the most value.	Carl James	12/08/21	~~07/07/22~~ 13/10/22	CJ has written to the Regional Partnership Boards – extract: 'I am seeking to understand what the key priorities are for each Regional Partnership Board for 2022 – 2025 to allow us to enter into further discussions with partners to determine where there is a need that we best assist and add the most value to the work.' To report back to Committee – either in next meeting or beforehand if next steps agreed	**OPEN**
3.1.0	Include further case study examples in the Enabling Strategies.	Carl James	16/05/22	September	Will be included in final Strategy launch	**OPEN**
3.1.0	Estates strategy - Noted also that the refurbished Llantrisant site, brand new cancer facility and brand-new Radiotherapy Satellite Centre will require a different type of skillset. CJ to accentuate this further in the document.	Carl James	16/05/22	07/07/22	Included in final version which was approved by the Trust Board in May.	**CLOSED**

Minute Ref.	Action	Assigned to	Meeting Date	Target Date	Progress to date	Status (Open / Closed)
3.1.0	GJ highlighted that in several places it states that we provide services from locations that we *own* when some are in fact leasehold. Suggested to replace *"own"* with *"occupy"* and this was **agreed**. Also noted that Welsh Blood in Dafen states that the lease runs until 2022 but AP reported that the lease has been extended and this amendment will be made.	Alan Prosser	16/05/22	07/07/22	Included in final version which was approved by the Trust Board in May.	**CLOSED**
3.1.0	Equality impact assessment to be finalised on Enabling Strategies	Carl James	16/05/22	07/07/22	Included in final version which was approved by the Trust Board in May.	**CLOSED**
3.1.0	SHarries suggested that to avoid repeated questions when presented to the Board, the cover paper be extended to include the key issues discussed at this Committee.	Carl James / Steve Ham / Lauren Fear	16/05/22	07/07/22	Included in final version which was approved by the Trust Board in May.	**CLOSED**
3.3.0	Queried how the Patient Engagement Strategy for the Health Board would dovetail with the same for VCC. COB explained that contact has already been made with the Patient Engagement leads at the Health Boards and work is underway with the network to establish whether what is being done in South East Wales can be extended for cancer patients across Wales. **Agreed** to strengthen this in the document and cover paper.	Cath O'Brien	16/05/22	07/07/22	Included in final version which was approved by the Trust Board in May.	**CLOSED**

Minute Ref.	Action	Assigned to	Meeting Date	Target Date	Progress to date	Status (Open / Closed)
3.8.0	AW gave a brief outline of the RD&I Highlight Report. JA noted that as this was their first Highlight Report to this Committee, feedback from the group in terms of future content is welcomed. Agreed that this should be provided by email outside of the meeting.	All	16/05/22	07/07/22	To agree closure in the Committee	**OPEN**

Strategic Development Committee

Developing the Welsh Blood Service 5 Year Strategy

DATE OF MEETING	07/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Richards, Head of Programmes and Service Improvement, WBS
PRESENTED BY	Alan Prosser, Director WBS
EXECUTIVE SPONSOR APPROVED	ALAN PROSSER, DIRECTOR, WBS

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB Shape	22/06/2022	Noted

ACRONYMS	
WBS	Welsh Blood Service
PBC	Programme Business Case
GMP	Good Manufacturing Practice

1. SITUATION/BACKGROUND

1.1 Work is currently underway to finalise the strategic vison and 5 Year Strategy for the Welsh Blood Service. This has been developed in conjunction with staff, donors and engagement with the Community Health Council (CHC); which will continue throughout the development process.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached presentation provides a progress update and the shape of the strategy.

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	Yes
	EQIA is underway
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 Strategic Development Committee is asked to **NOTE** the contents of the presentation and receive a final draft strategy for consideration.

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Welsh Blood and Transplant Services Five Year Strategy

Progress Update

July 2022

Our Vision

To be a leader in blood, transplant and transfusion services, continually evolving to meet changing health requirements.

Our Strategic Themes

Strategic Theme 1	Grow our donor base to meet clinical need and represent the diverse communities we serve
Strategic Theme 2	Deliver the best possible experience for donors, advocates and partners
Strategic Theme 3	Drive the prudent use of blood across Wales
Strategic Theme 4	Modernise our operations to improve safety, productivity and value
Strategic Theme 5	Develop new and innovative services to improve outcomes
Strategic Theme 6	Sustainable services that deliver the greatest value to our communities
Strategic Theme 7	Develop great people and a great place to work

Gwasanaeth Gwaed Cymru
Welsh Blood Service

How will we deliver?

(examples to show direction of travel)

Grow our donor base to meet clinical need and represent the diverse communities we serve

We will …

- Deepen our collaboration with partners who can reach and engage with public on our behalf
- Introduce new technology to target, engage and motivate donors more effectively
- Use behavioural insights to better understand our donors

Deliver the best possible experience for our donors, advocates and partners

We will …

- Introduce an updated and improved website
- Introduce tailored, automated pathways for donors designed to improve relationships
- Develop a donor app to empower donors to self service
- Use data to tailor messages for the best outcomes

Drive the prudent use of blood across Wales

We will …

- Work collaboratively to support effective planning and management of the blood supply chain
- Use evidence and data to support service planning and reduce inappropriate variation
- Standardise procedures, guideline and policies to promote a safe and consistent approach across Wales

Modernise our operations to improve safety, productivity and value

We will …

- Streamline, digitise and automate our processes
- Optimise our operational footprint and staffing models
- Adopt integrated approach to gain efficiencies from scale
- Drive continuous improvement

Develop new and innovative services to improve outcomes

We will …

- Align our processes and systems with major developments in science, infrastructure, technology and informatics
- Establish systematic approaches to horizon scanning
- Integrate system wide data sets to develop insights

Sustainable services that deliver the greatest value to our communities

We will …

- Work collaboratively to improve all aspects of biodiversity and environmental sustainability
- Work with local community organisations to deliver environmental sustainability initiatives
- Utilise digital technology to improve efficiency and minimise waste
- Be carbon neutral by 2030

Develop great people and a great place to work

We will …

- Develop our strategic workforce planning
- Provide excellent learning and development opportunities
- Deliver more integrated and collaborative working with health, academia and industry
- Support increased academic and vocational training and development
- Undertake robust succession planning

Next Steps …

- Continue to develop and refine in partnership with our staff.
- Engage with Community Health Council (CHC) and donors.

STRATEGIC DEVELOPMENT COMMITTEE

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK: PILOT

DATE OF MEETING	07/07/2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Peter Gorin, Head of Corporate Strategic Planning and Performance
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
WBS SMT	9 March 2022	**ENDORSED**
VCC SLT	22 March 2022	**ENDORSED**
PMF Project Group	5 April 2022	**ENDORSED**
Community Heath Council	26 April 2022	**DISCUSSED**
Executive Management Board	10 May 2022	**ENDORSED**
Strategic Development Committee	16 May 2022	**ENDORSED**
Executive Management Board	22 June 2022	**ENDORSED**
Note: Meetings have also been held with Independent Trust Board members, members of staff who contribute to the PMF and with the Community Health Council.		

ACRONYMS	
VUNHST	Velindre University NHS Trust
QSP	Quality, Safety and Performance Committee
EMB	Executive Management Board
SLT	Senior Leadership Team
PMF	Performance Management Framework
QSF	Quality Safety Framework
KPI	Key Performance Indicators
SPC	Statistical Process Control Charts

1. A significant amount of work has been undertaken in evolving the Trust Performance Management Framework (PMF). The revised approach uses a 'balanced scorecard' approach and the six domains' of the Quality Safety Framework (QSF), namely safe, effective, and patient/donor centered, timely, efficient and equitable care. The approach is set out in the presentation attached as Appendix A.

1.1 The revised PMF will include a range of scorecards:-

- Trust scorecard
- Executive Management Board Scorecard
- Service level scorecards for cancer and blood services
- Support service scorecards (estates, digital, sustainability, workforce etc)

1.2 The scorecards are all aligned around the delivery of the Trusts' strategic goals and service standards i.e. cancer, blood and support functions.

2. PERFORMANCE MANAGEMENT FRAMEWORK SCORECARDS - PROPOSED

The draft Trust Board Scorecard and Performance Report

2.1 The revised Trust Board scorecard is set out at Annex B. The supporting Performance Report is attached as Annex C with a small number of key performance indicators 'mocked up' using April 2021 to March 2022 data for illustrative purposes only. The supporting narrative has not been completed as this is not seen as value adding at this juncture.

Navigating the PMF Performance Report

2.2 Performance against individual KPIs will no longer 'RAG rated' in the traditional way. Performance will be assessed as either 'within standard' ✓or 'outside standard' × against any particular target or best practice measure for the current month, plus an assessment of the 15 month 'rolling data trend' seen, as either 'improving' 🡅, or 'stable' ➔, or 'declining' 🡇

2.3 The actual performance for each KPI is measured against a national standard or local stretch target on a monthly, quarterly or annual basis set against a baseline at the start of each financial year.

2.4 Each KPI is supported by data that explains the current performance using, wherever possible, Statistical Process Control (SPC) Charts. This will enable the distinction to be made between 'natural variations' in performance and trends or performance requiring investigation i.e. where there is an issue which requires urgent action to improve. The scorecards incorporate hyperlinks to supporting KPI data, enabling switching from the high-level position to detailed analysis and back.

Piloting the revised approach

2.5 The revised approach requires piloting to identify any unforeseen issues in advance of a formal 'Go Live' implementation. It is proposed that the pilot commences in July 2022 with the aim, subject to successful pilot of implementing the new Trust, service level and support function scorecards in the October/November 2022 governance cycle i.e. the Quality, Safety and Performance Committee and Trust Board would receive the new and revised reports at the planned November meetings 2022.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
	Quality and Safety considerations form an integral part of the Trust IMTP (2022/23 - 2024/25) and the PMF is the Trust mechanism for monitoring and reporting on progress against the key objectives outlined in our IMTP.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Staff and Resources Safe Care Timely Care Effective Care Staying Healthy
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)
	VUNHST IMTP 2022/23 to 2024/25 plans must be delivered within the Trust's financial allocation.

4. RECOMMENDATIONS

4.1 The Strategic Development Committee is asked to:

- **NOTE** the revised Trust Board scorecard (Annex B) and performance report for piloting (Annex C);
- **NOTE** the pilot period of the PMF; and
- To receive a further report setting out the learning from the pilot and a final set of scorecards and performance report for implementation in November 2022.

Appenidix A PMF Methodology and Approach

See attached presentation

Appendix B Draft Trust Board Scorecard as at March (Month 12) 2022 – for illustrative purposes only

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 12 (March)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Rolling data trend	
Safety	% compliance for staff completed the Statutory Core Skills and Training Framework Level 1 competences	National	Monthly	85%	85%	86%	✓	↑	KPC.19
	Number of Serious Untoward Incidents recorded and investigated with negative outcome	Local	Monthly	0	0	0	✓	→	KPV.29
	Number of VCC Inpatient Falls per month Target 0 Avoidable	Local	Monthly	3	0	9	✗	→	KPV.02
	Number of Staff RIDDOR Incidents, injuries and work-related accidents	Local	Monthly	5	0	0	✓	→	KPC.14
	Number of Never Events (definition specific to cancer services)	Local	Monthly	0	0	0	✓	→	KPV.30
	Number Healthcare Acquired Infections MRSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare Acquired Infections MSSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare Acquired Infections P. aeruginosa	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare Acquired Infections Klebsiella spp. bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare Acquired Infections C Difficile	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare Acquired Infections E Coli	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare Acquired Infections Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Antibiotic usage within the WHO Access category of total antibiotic consumption	National	Monthly	TBA	≥55%	TBA	✓	→	KPV.41
	Compliance with the principles of 'Start Smart then Focus'.	National	Monthly	TBA	TBA	TBA	✓	→	KPV.42
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	Local	Monthly	1	0	1	✗	→	KPV.01
	Serious Adverse Blood Reactions & Events (SABRE) reported to Medicines Healthcare Regulation Agency	Local	Monthly	1	0	0	✓	→	KPI.30
	% reduction in Carbon Footprint/Emissions by 2025 against 2021/22 baseline	National	Quarterly	TBA	-16%	TBA	✓	→	KPC.06

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 12 (March)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Rolling data trend	
Effectiveness	SACT 30 Day Mortality –Professional NHS Standard	Prof. Std.	Quarterly	TBA	TBA	TBA	✓	➔	KPV.06
	Number of Delayed Transfers of Care (DToCs)	National	Monthly	1	0	1	✖	🡻	KPV.05
	Patient Reported Outcome Measures (PROMS)	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPV.08
	Research published with actual impact on service	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPV.09
	Number of Health and Care Research Wales portfolio & commercially sponsored studies	Local	Annually	TBA	TBA	TBA	✓	➔	KPV.31
	Number of patients recruited to Health and Care Research Wales research portfolio & commercially sponsored studies	Local	Annually	TBA	TBA	TBA	✓	➔	KPV.33
	Red Blood Cell % of hospital demand met manufactured bags with no imported blood	Best practice	Monthly	112%	100%	100%	✓	➔	KPI.04
	Time expired adult Red Blood Cell bags as % of total RBC bags manufactured in month	Local	Monthly	0.10%	Max 1%	0.08%	✓	➔	KPI.26
	Time expired adult Platelet bags as % of total platelets manufactured in month	Local	Monthly	12%	Max 10%	12.5%	✖	➔	KPI.25
	WBMDR Number of Stem Cell transplants supported 80 per annum	National	Monthly	50	70	47	✖	➔	KPI.13
	% Staff sickness levels 12 month reduction trend measured against rolling average target	National	Monthly	5.5%	3.54%	5.66%	✖	🡻	KPC.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers and supervisors	National	Monthly	65%	85%	69%	✖	➔	KPC.36
	Delivering wider social value (Sustainable Development Assessment Tool (SDAT)	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPC.25

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 12 (March)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Rolling data trend	
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as excellent	Local	Monthly	70%	80%	80%	✓	➔	KPV.11
	% of Donors Who Rate Experience at WBS as excellent	Local	Monthly	95%	90%	96%	✓	➔	KPI.09
	Number VCC formal complaints received under Putting Things Right within 30 days	Local	Monthly	TBA	TBA	TBA	✓	➔	KPV.12
	% WBS 'formal' concerns that have received a final reply within 30 working days Regulation 24 'Putting Things Right	Local	Monthly	90%	90%	100%	✓	➔	KPI.11
	% staff who rate us as a good employer in Annual Staff Survey	National	Annually	TBA	Annual Improvement	TBA	✓	➔	KPC.13
Timeliness	% Radiotherapy treatment JCCO Radical within 28 days	National	Monthly	94%	98%	92%	✖	➔	KPV.14
	Palliative within 14 days	National	Monthly	98%	98%	81%	✖	➔	KPV.15
	Emergency within 2 days	National	Monthly	100%	98%	88%	✖	➔	KPV.16
	% Patients Begin SACT Non-Emergency within 21 days	National	Monthly	95%	98%	71%	✖	➔	KPV.20
	Emergency within 5 days	National	Monthly	100%	100%	83%	✖	➔	KPV.21
	% of Routine Antenatal Patient testing results provided to hospitals within 3 working days	Best practice	Monthly	90%	90%	96%	✓	➔	KPI.17
	H & I turnaround service response times from sample receipt to reporting within 5 working days	Best practice	Quarterly	90%	90%	90%	✓	➔	KPI.21
	Donor Appointments Percentage of on the day or pre planned session donor deferrals	Local	Monthly	15%	Max 10%	12%	✓	➔	KPI.07

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 12 (March)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline	Target	Actual	In Month Position	Rolling data trend	
Efficient	Financial Balance – % achievement of forecast in line with revenue expenditure profile to achieve financial balance	National	Monthly	0%	0%	0%	✓	➔	KPC.71
	% achievement of capital expenditure in line with forecast profile to achieve annual Cash Resource Limit	National	Monthly	£10.1m	£10.1m	£10.1m	✓	➔	KPC.73
	Overtime Bank and Agency staff % of overall workforce pay bill, taken from Financial Monitoring Returns	National	Monthly	TBA	Annual Reduction	TBA	✓	➔	KPC.72
	Cost Improvement Programme: % achievement of annual forecast in line with savings profile	National	Monthly	£1.1m	£1.1m	£1.1m	✓	➔	KPC.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	93%	✗	➔	KPC.60
	Energy: gas consumption compared to 2021/22 levels	Local	Quarterly	-3%	-3%	-3%	✓	➔	KPC.62
	Energy: electric consumption compared to 2021/22 levels	Local	Quarterly	-3%	-3%	-3%	✓	➔	KPC.63
	Delivery of IMTP 2022/23 Quarterly Action plans % of actions implemented in line with deadlines	Local	Quarterly	100%	100%	100%	✓	➔	KPC.70
Equitable	% Welsh Speakers in Trust	National	Quarterly	TBA	TBA	TBA	✓	➔	KPC.81
	Diversity of Workforce (Gender) - % females in workforce - % females in senior leadership/Board roles - Gender Pay differentials	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPC.78
	Diversity of Workforce (ethnicity) - % BME in workforce - % black ethnic minority in senior leadership/Board	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPC.79
	Diversity of Workforce (disability) - % registered disabled in workforce	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPC.80
	Equity agreed measures to be developed proxy Equality Impact Assessments	Local	Quarterly	TBA	TBA	TBA	✓	➔	KPC.77

Symbols Key: In Month Performance = Compliant ✓ Non-compliant ✗ Year to date trend = Improving ↑ stable ➔ deteriorating ↓

Appendix C: Performance Report (trial version using April 2021 – March 2022 data for illustrative purposes)

KPI Indicator KPV.01

Return to Top

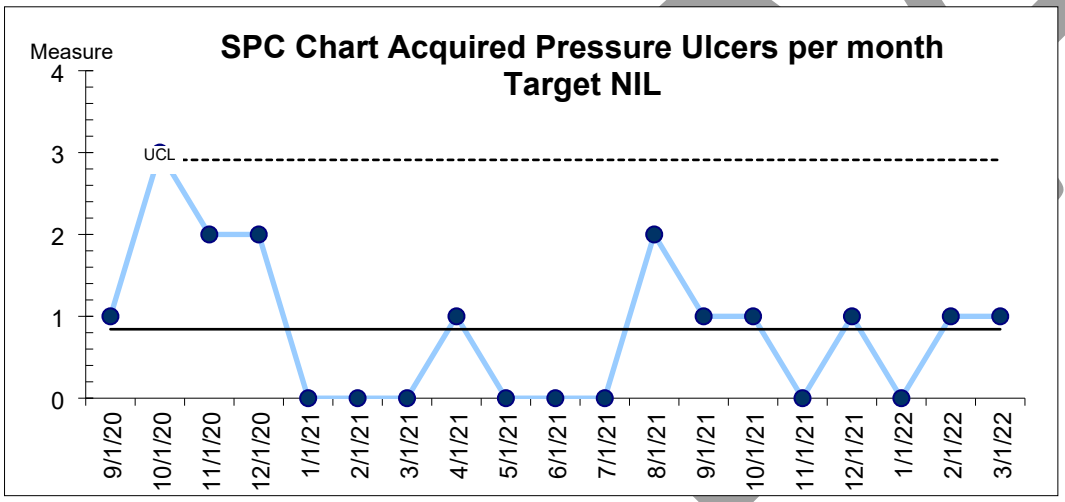
Number of VCC Acquired Pressure Ulcers per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual Number	0	0	0	1	0	0	0	2	1	1	0	1	0	1	1
Avoidable Ulcers				1				1							
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 19 months.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator KPV.02

Return to Top

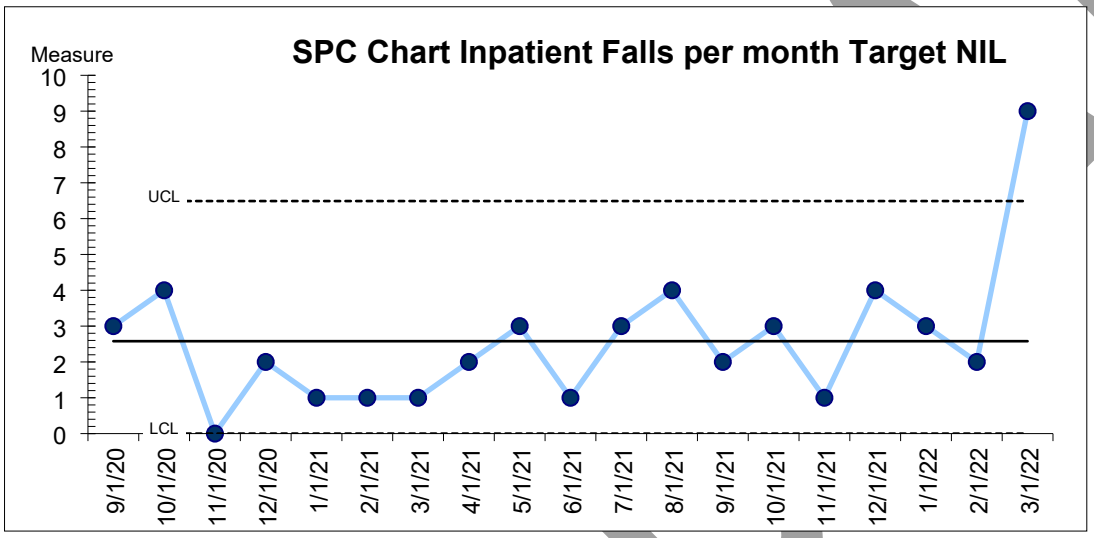
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual Number	1	1	1	2	3	1	3	4	2	3	1	4	3	2	9
Avoidable Falls				1					1				1		
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 19 months, with a 'special cause' variation of 9 falls in the current month.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

ANNEX 2: EFFECTIVENESS

KPI Indicator KPV.05

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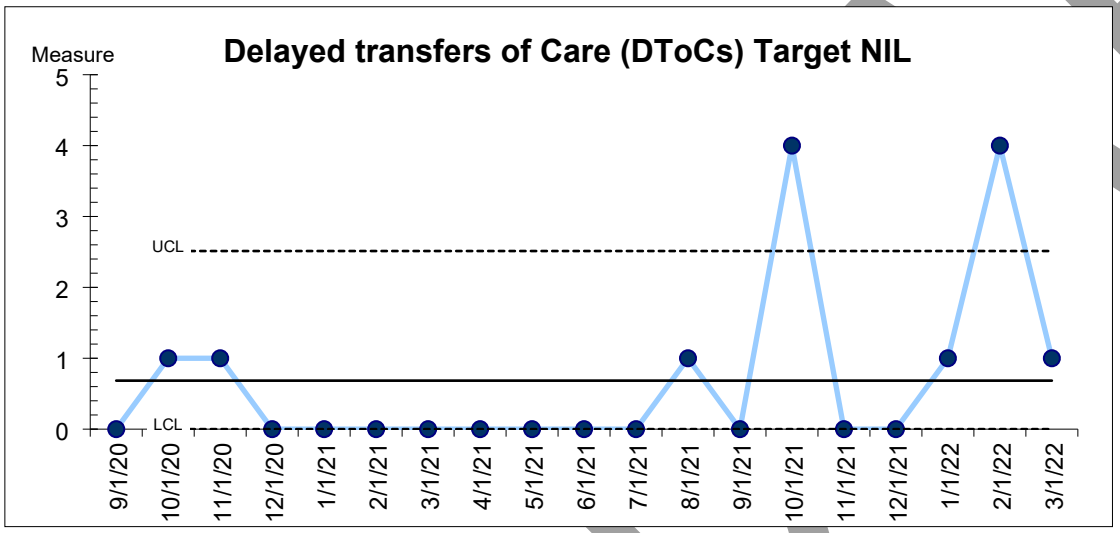
Number of Delayed Transfers of Care (DToC)

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

VCC	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual %	0	0	0	0	0	0	0	1	0	**4**	**0**	0	1	4	1
Target NIL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**



SPC Chart Analysis

The SPC Chart shows two 'special cause' or exceptional variations in October 2021 and January 2022.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator KPI.04

Return to Top

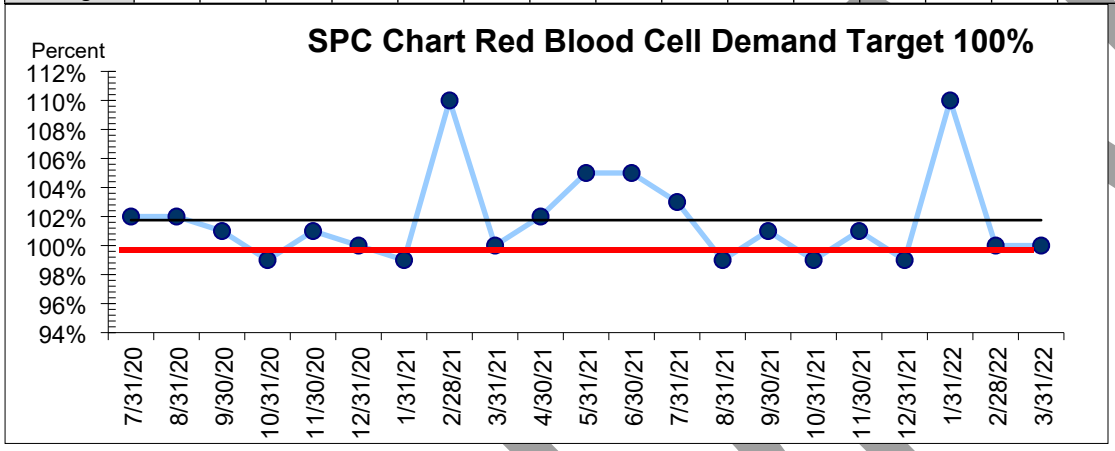
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals

Target: 100%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual %	99	110	100	102	105	105	103	99	101	99	101	99	110	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Bags issued	6400	6253	6253	6010	6078	5457	6934	6780	6064	6580	6361	6638	6445	6780	6064
Total RBC Bags	6464	6190	6316	6010	6017	6003	6934	6916	6367	6909	6552	6572	6509	6916	6367



SPC Analysis

The SPC chart above, shows common cause or normal variation for the period April to September 2021, with some outperformance April to July 2021.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator KPI.25

Return to Top

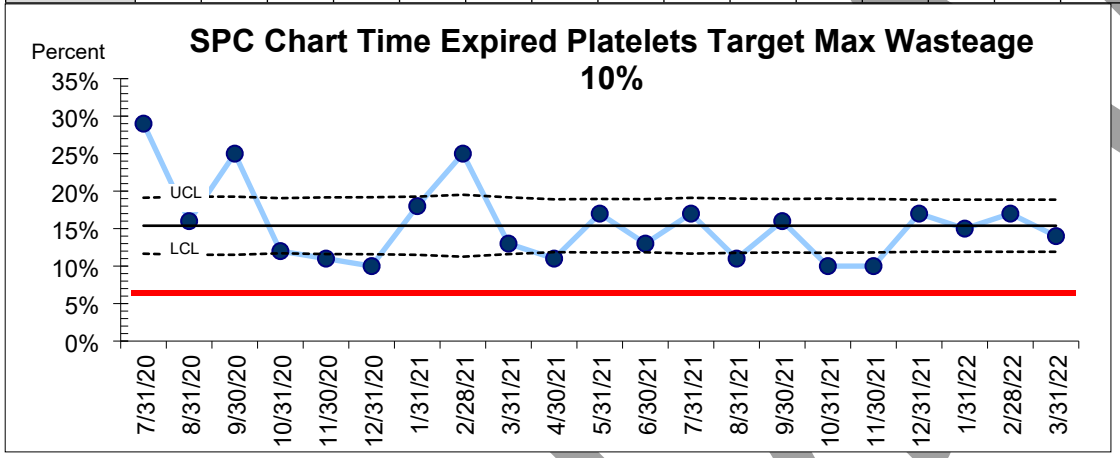
Time Expired Platelets as a Percentage of Total Platelet Production

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual %	18	25	13	11	17	13	17	11	16	10	10	17	15	17	14
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Wastage	140	172	106	104	156	121	144	98	148	89	92	165	146	165	136
Total Platelets	777	687	817	944	919	932	847	894	922	894	922	970	970	970	970



SPC Analysis

The SPC chart above, shows common cause or normal variation for the period April to September 2021.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator KPI.26

Return to Top

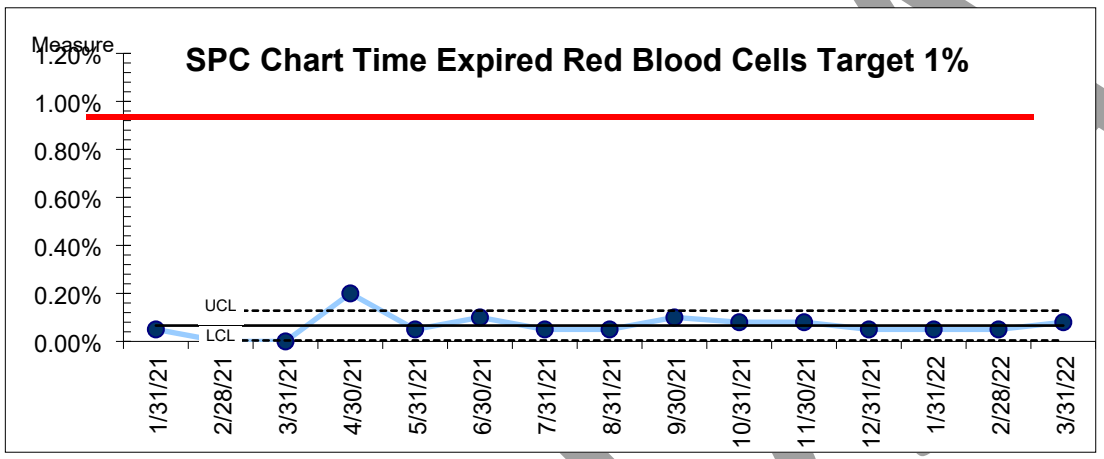
Time Expired Red Blood Cells as a Percentage of Total RBC Production

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual %	0.05	0	0	0.2	0.05	0.1	0.05	0.05	0.1	0.08	0.08	0.05	0.05	0.05	0.08
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Wastage															
Total RBC															



SPC Analysis

The SPC chart above, shows common cause or normal variation for the period January to September 2021, remaining well below the maximum wastage target

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator KPC.36

Return to Top

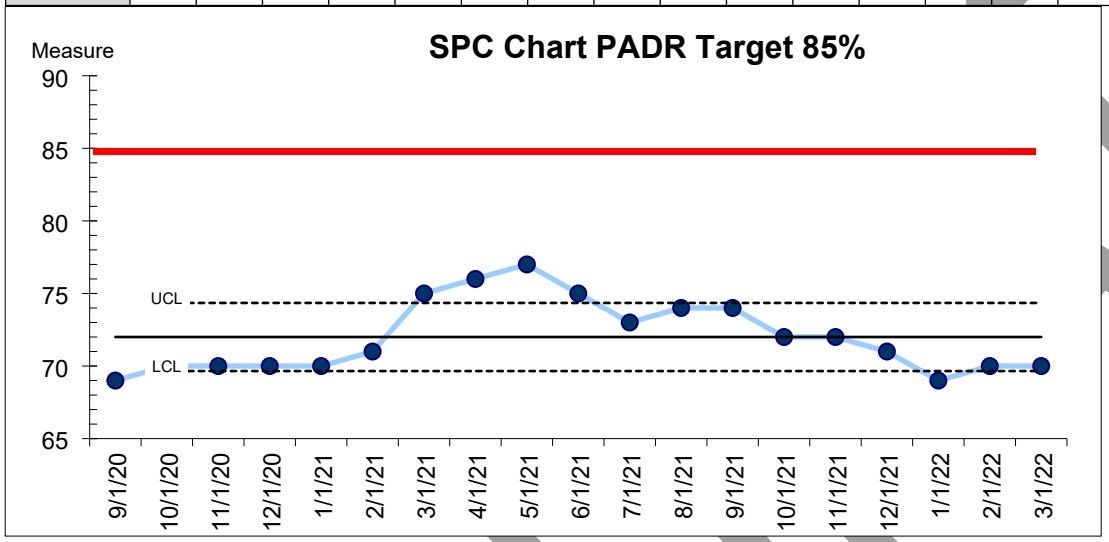
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: VCC Director

Current Performance against Target or Standard

Trust Position	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual %	70	71	75	76	77	75	73	74	74	72	72	71	69	70	70
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows some improvement from Jan to June 21 months, but returning to averaging 73%, and consistently falling short of the 85% target.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator KPC.37

Return to Top

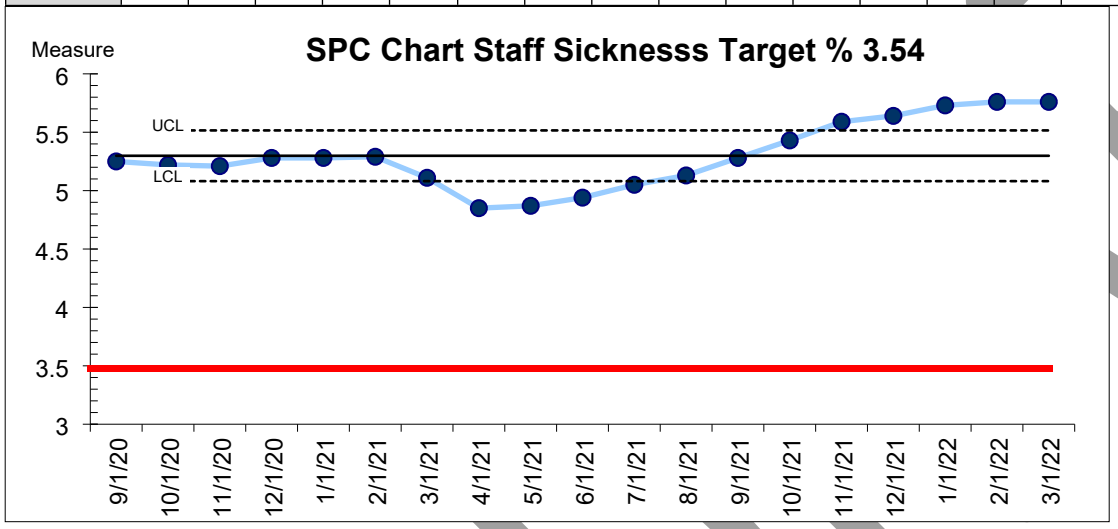
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: VCC Director

Current Performance against Target or Standard

Trust Position	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Actual %	5.28	5.29	5.10	4.85	4.87	4.94	5.05	5.13	5.28	5.43	5.59	5.64	5.73	5.76	5.76
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

The SPC chart shows a deteriorating trend over the last 8 months with the overall average 5.2% sickness level remains higher than the 3.54% target

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

Velindre University NHS Trust Performance Management Framework

Strategic Development Committee

7th July 2022

Agenda:

1. Why the need for change
2. Approach and methodology
3. Measuring the right things
4. Performance and assurance: escalation
5. Who's been involved
6. Next steps

1 - Why the Need for Change?

Why the need for change

- **Measures:** are we measuring the right things or things we can measure ?
- **Philosophy:** pass/fail or measurement for improvement ?
- **Presentation:** presentation of information not always useful e.g. this month against last month
- **Analysis:** Often lacking i.e. why is it happening, what are we doing about it?
- **Intelligence:** One dimensional view of performance with limited triangulation and limited insights e.g. relationship between cause and effect from input > throughput > output > outcome
- **Clarity on purpose:** often same reports going to various stakeholders with no distinction on purpose
- **Language:** needs to address the audience e.g. public or management
- **Process**: Insufficient automation/labour intensive
- **Timeliness:** Lag times with data availability

Velindre University NHS Trust

Draft from initial engagement

Mission

Supporting people to live their best lives

Vision

Healthy People,
Excellent Care,
Inspirational Learning

2 – Approach and Methodology

Methodology and Approach

- Philosophy: continuous improvement versus pass/fail measurement for improvement?

- Performance Framework: Balanced scorecard versus scorecard using QSF quality dimensions?

PERFORMANCE DELIVERY
- RT/SACT waits
- RBC/Platelets delivery
- O/P & Donor Appointments
- Blood Results

SAFETY & QUALITY
- HAI's/SABRE/S&M
- SUI's/Never Events
- Patient/Donor Experience
- PROMs & PREMs

PEOPLE & WELLBEING
- PADR/Sickness/Staff Survey
- Diversity
- Decarbonisation
- Welsh Language

FINANCE & RESOURCES
- Financial Balance/Agency
- Value-based Healthcare
- Digital Inclusion
- Estates

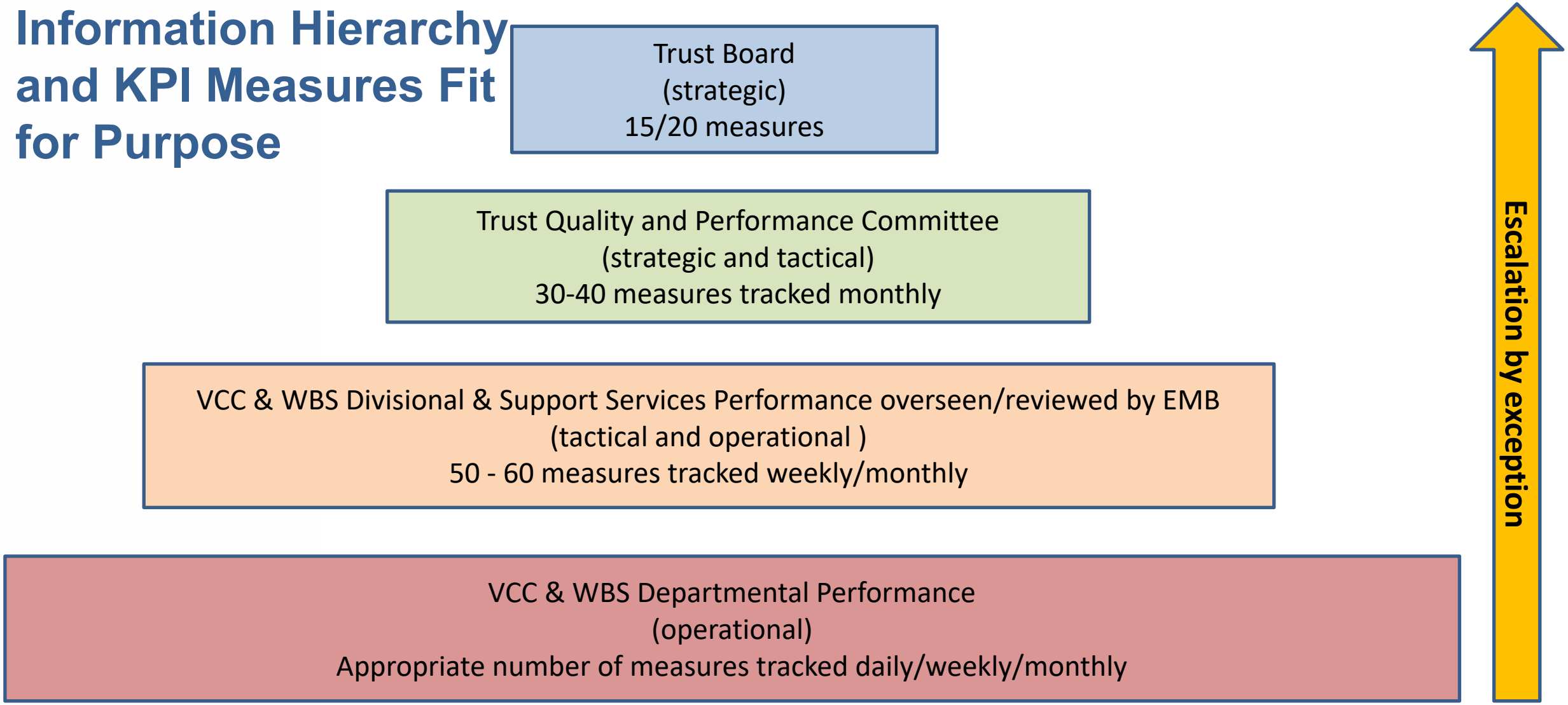
- Presentation: performance against targets, in month, annual improvement, Bar charts, SPC run charts, tables

- Analysis of Results: 'what, where and when' shown by graphs & tables; narrative focus on 'why, how and who'

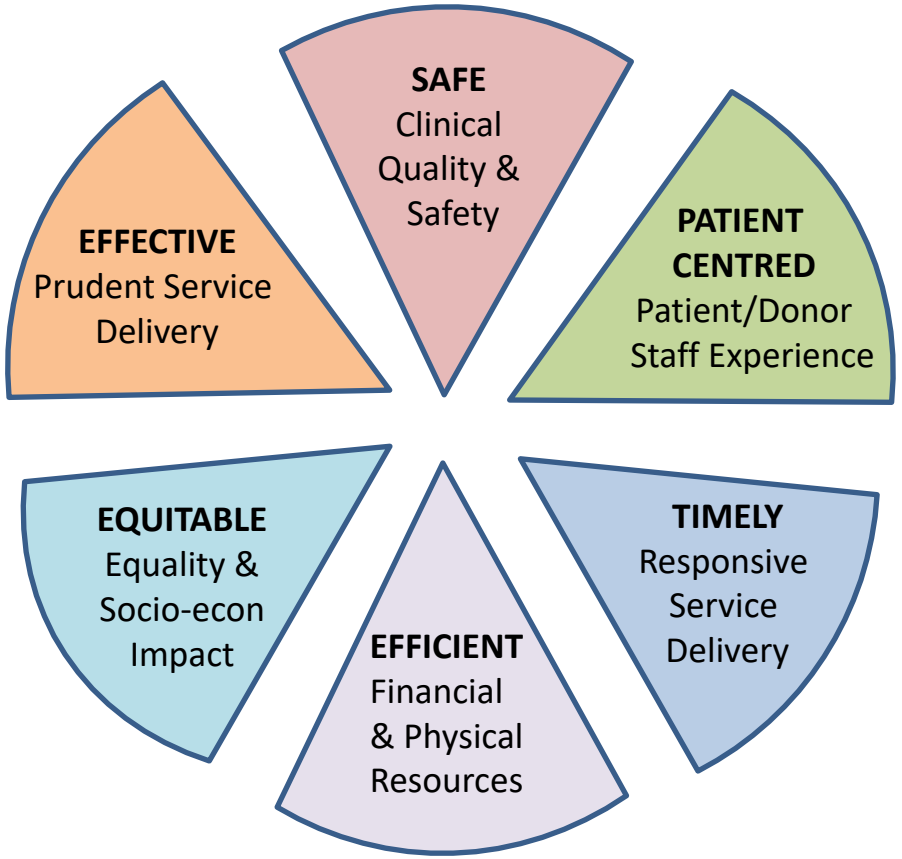
- Reporting: Trust Board; QSP; EMB; SLT; Departments hierarchies and escalation by exception

- The IMTP focuses on our future strategic goals and how they will be achieved; the PMF concentrates on how well services are being delivered for patients and donors today

Information Hierarchy and KPI Measures Fit for Purpose



Consolidated Performance Management Framework
'Quality and Safety Framework Format'



Welsh Blood Service

3 – Measuring the Right Things

Trust Board PMF Scorecard – based on QSF domains

QSF Domain	Trust Board Performance Scorecard: KPI Measure	Target	Reported	Performance as at Month 10 (Jan): Baseline	Target	Actual	Compliance against Target or Standard: In Month Position	Year to date trend	Data Link
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	85%	85%	86%	✓	→	KPC.19
	Number of Serious Untoward Incidents recorded and investigated with negative outcome	Local	Monthly		TBA		✓	→	KPV.29
	Number of Staff RIDDOR Incidents, injuries and work-related accidents	Local	Monthly	5	0	0	✓	→	KPC.13
	Number of Never Events (definition specific to cancer services)	Local	Monthly	0	0	0	✓	→	KPV.30
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Diff	National	Monthly	0	0	1	×	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	0	✓	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	Local	Monthly	4	0	0	✓	→	KPV.01
	Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines Healthcare products Regulation Agency (MHRA)	Local	Monthly	1	0	0	✓	→	KPI.30
	% reduction in Carbon Footprint/Emissions 16% reduction by 2025 against 2021/22 baseline	National	Quarterly		TBA		✓	→	KPC.06

QSF Domain	Trust Board Performance Scorecard: KPI Measure	Target	Reported	Performance as at Month 10 (Jan): Baseline	Target	Actual	Compliance against Target or Standard: In Month Position	Year to date trend	Data Link
Effectiveness	SACT 30 Day Mortality –Professional NHS Standard	Prof. Std.	Quarterly		TBA		✓	→	KPV.06
	Patient Reported Outcome Measures (PROMS)	Local	Quarterly		TBA		✓	→	KPV.08
	Research published with actual impact on service	Local	Quarterly		TBA		✓	→	KPV.09
	Number of Health and Care Research Wales portfolio & commercially sponsored studies	Local	Annually		TBA		✓	→	KPV.31
	Number of patients recruited to Health and Care Research Wales research portfolio & commercially sponsored studies	Local	Annually		TBA		✓	→	KPV.33
	Red Blood Cell % of hospital demand met for manufactured bags with no imported blood required – Professional NHS Standard	Prof. Std.	Monthly	112%	100%	111%	✓	→	KPI.04
	Time expired adult Red Blood Cell bags as % of total RBC bags manufactured in month	Local	Monthly	0.10%	Max 1%	0.05%	✓	→	KPI.26
	Time expired adult Platelet bags as % of total platelets manufactured in month	Local	Monthly	12%	Max 10%	15%	×	→	KPI.25
	WBMDR Number of Stem Cell transplants supported 80 per annum – Professional NHS Standard	Prof. Std.	Monthly	50	70	39	×	→	KPI.13
	% Staff sickness levels 12 month reduction trend measured against rolling average target	National	Monthly	5.5%	3.54%	5.66%	×	↓	KPC.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers and supervisors	National	Monthly	65%	85%	69%	×	↑	KPC.36
	Delivering wider social value (Sustainable Development Assessment Tool (SDAT)	Local	Quarterly		TBA		✓	→	KPC.25

QSF Domain	Trust Board Performance Scorecard: KPI Measure	Target	Reported	Performance as at Month 10 (Jan): Baseline	Target	Actual	Compliance against Target or Standard: In Month Position	Year to date trend	Data Link
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as excellent	Local	Monthly	70%	80%		✓	→	KPV.11
	% of Donors Who Rate Experience at WBS as excellent	Local	Monthly	95%	90%	96%	✓	→	KPI.09
	Number VCC formal complaints received under Putting Things Right within 30 days	Local	Monthly		TBA		✓	→	KPV.12
	% WBS 'formal' concerns that have received a final reply within 30 working days under Regulation 24 'Putting Things Right	Local	Monthly	90%	90%	88%	×	→	KPI.11
	% staff who rate us as a good employer in Annual Staff Survey	National	Annually		Annual Improve		✓	→	KPV.13
Timeliness	Patients Radiotherapy treatment JCCO Radical within 28 days	National	Monthly	94%	98%	92%	×	→	KPV.14
	Palliative within 14 days	National	Monthly	98%	98%	98%	✓	→	KPV.15
	Emergency within 2 days	National	Monthly	100%	98%	100%	✓	→	KPV.16
	Patients Begin SACT Non-Emergency within 21 days	National	Monthly	95%	98%	94%	×	↑	KPV.20
	Emergency within 2 days	National	Monthly	100%	100%	100%	✓	↑	KPV.21
	% of Routine Antenatal Patient testing results provided to hospitals within 3 working days – Professional NHS Standard	Prof. Std.	Monthly	90%	90%	92%	✓	→	KPI.17
	H & I turnaround service response times from sample receipt to reporting within 5 working days – Professional NHS Standard	Prof. Std.	Quarterly	90%	90%		✓	→	KPI.21
	Donor Appointments Percentage of on the day or pre planned session donor deferrals	Local	Monthly	15%	Max 10%		✓	→	KPI.07

QSF Domain	Trust Board Performance Scorecard: KPI Measure	Target	Reported	Performance as at Month 10 (Jan): Baseline	Target	Actual	Compliance against Target or Standard: In Month Position	Year to date trend	Data Link
Efficient	Financial Balance – % achievement of forecast in line with revenue expenditure profile to achieve financial balance	National	Monthly	0%	0%	0%	✓	→	KPC.71
	% achievement of capital expenditure in line with forecast profile to achieve annual Cash Resource Limit	National	Monthly	£10.1m	£10.1m	£10.1m	✓	→	KPC.73
	Overtime Bank and Agency staff % of overall workforce pay bill, taken from Financial Monitoring Returns	National	Monthly		Annual reduced	Annual reduced	✓	→	KPC.72
	Cost Improvement Programme: % achievement of annual forecast in line with savings profile	National	Monthly	£1.1m	£1.1m	£1.1m	✓	→	KPC.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	93%	×	→	KPC.60
	Energy: gas consumption compared to 2021/22 levels	Local	Quarterly	-3%	-3%	-3%	✓	→	KPC.62
	Energy: electric consumption compared to 2021/22 levels	Local	Quarterly	-3%	-3%	-3%	✓	→	KPC.63
	Delivery of IMTP 2022/23 Quarterly Action plans % of actions implemented	Local	Quarterly	100%	100%	100%	✓	→	KPC.70
Equitable	% Welsh Speakers in Trust	National	Quarterly		TBA		✓	→	KPC.81
	Diversity of Workforce (Gender) - % females in workforce - % females in senior leadership/Board roles - Gender Pay differentials	Local	Quarterly		TBA		✓	→	KPC.78
	Diversity of Workforce (ethnicity) - % BME in workforce - % black ethnic minority staff in senior leadership & Board roles	Local	Quarterly		TBA		✓	→	KPC.79
	Diversity of Workforce (disability) - % registered disabled in workforce	Local	Quarterly		TBA		✓	→	KPC.80
	Equity agreed measures to be developed proxy Equality Impact Assessments	Local	Quarterly		TBA		✓	→	KPC.77

Symbols Key: In Month Performance – Compliant ✓ Non-compliant × Year to date trend – Improving ↑ stable → deteriorating ↓

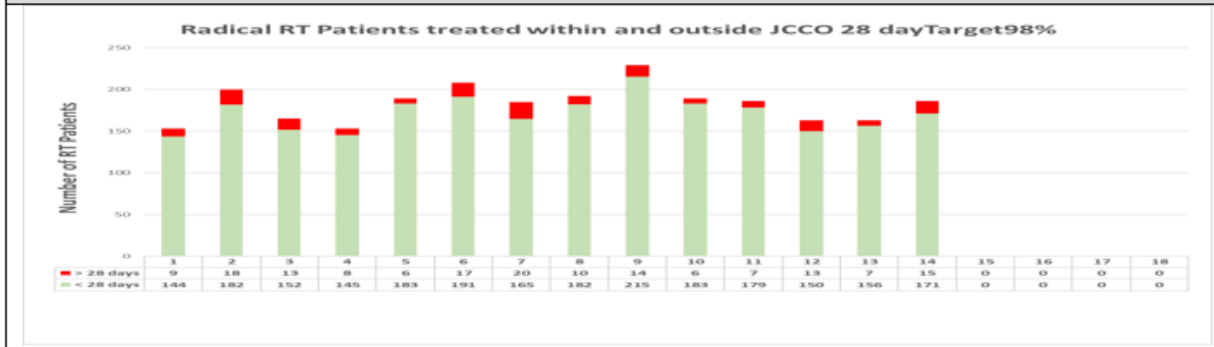
KPI Supporting Data Template e.g. Radiotherapy

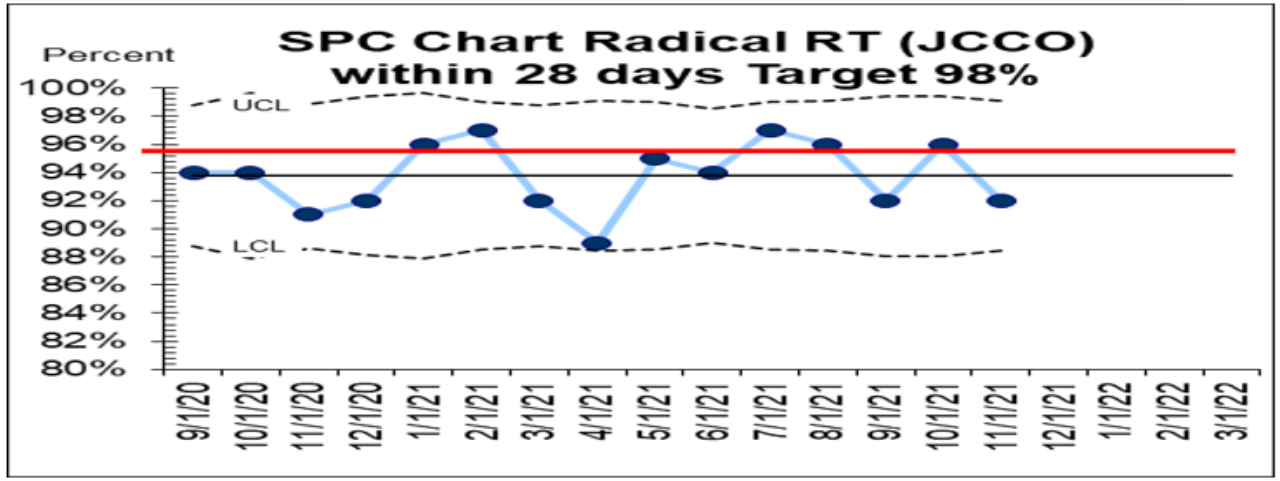
Radical Radiotherapy Patients Treated Within 28 Days (JCCO)

Target: 98%

SLT Lead: Radiotherapy Services Manager

Current Performance against Target or Standard





SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months. However, the average performance of 94% consistently falls below the 98% target.

Performance

If performance is not at required level, set out what the main causes are:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
• insert text	XX/XX/XX	AN Other
• insert text		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Supporting Data Template e.g. Expired Platelets

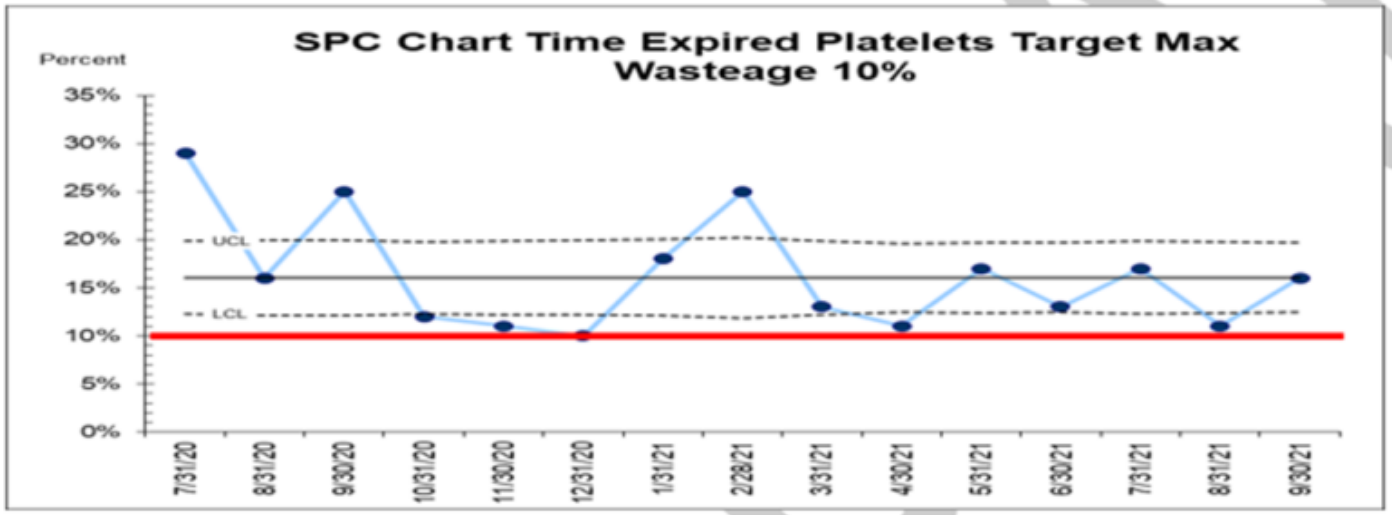
Time Expired Platelets as a Percentage of Total Platelet Production

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	29	16	25	12	11	10	18	25	13	11	17	13	17	11	16
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Wastage	244	125	195	104	90	81	140	172	106	104	156	121	144	98	148
Total Platelets	841	780	780	866	820	811	777	687	817	944	919	932	847	894	922



SPC Analysis

The SPC chart above, shows common cause or normal variation for the period April to September 2021.

Performance Trends and System Capability

The **'what, where and when'** of the KPI performance is already shown in the table and graph opposite i.e. **What** the %'s are; **Where** it happened and **When** performance improved/declined. There is no need to repeat this.

Describe here more the **'why, how and who'** underneath the figures i.e. **Why** performance happened; **How** we will improve and **Who** is the Lead responsible i.e. this is about what changes are needed to the way the system operates, to ensure it routinely achieves the target

Service Improvement Actions

Actions:	Timescale:	Lead:
Action one	XX/XX/XX	AN Other
Action two	XX/XX/XX	AN Other
Action three	XX/XX/XX	AN Other

Support Services KPI Templates e.g. Energy Consumption

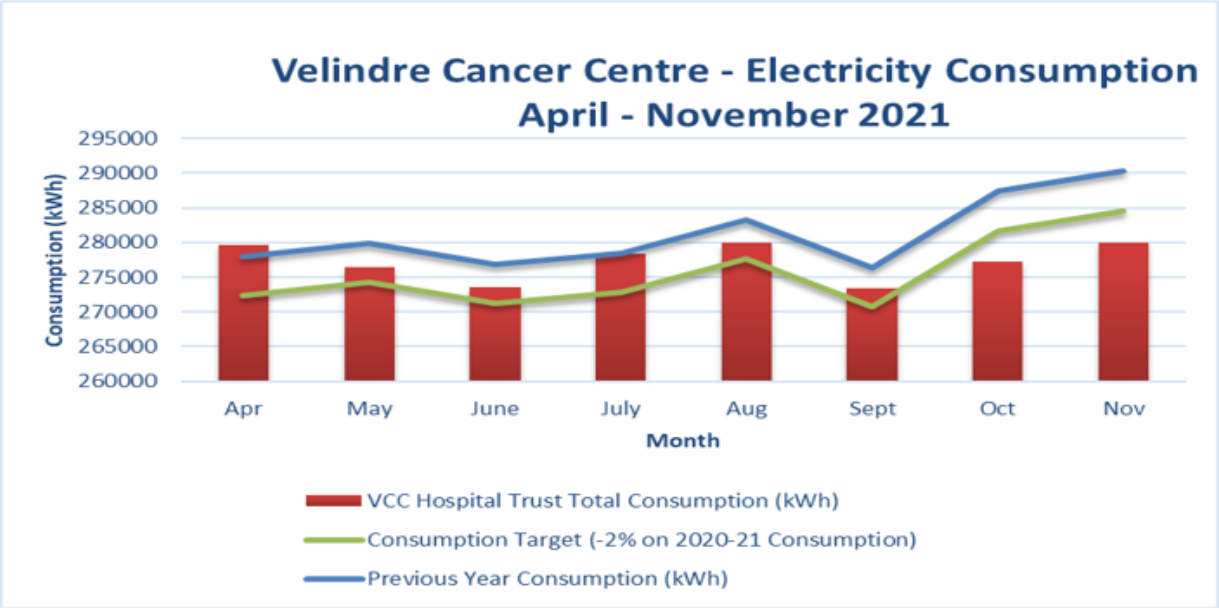
VCC - Energy (Gas & Elect) performance consumption -3% on 2020/21

Target: -3% 0 2020/21 Consumption

SLT Lead: Operations Director

Current Performance against Target or Standard

Trust Position	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual Number															
Target -3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%



Performance

If performance is not at required level, set out what the main causes are:

- Ongoing LED lighting upgrades across the site (both internal and external lighting) has continued to be undertaken the financial year.
- The Trust has obtained funding for a BMS upgrade, which will be delivered before the end of the financial year this will provide further controls and reduction in usage will follow.
- There was an increase in usage - increased heating in the building - due to the temperature.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Building Management System installed (tender completed) • Ongoing monitoring	April 2022 April 2022	Estates Manager Environ Manager

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Metering strategy development	2022/23	Estates Manager

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

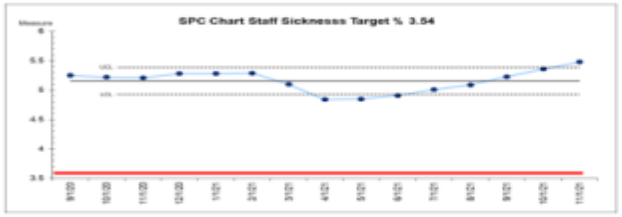
Support Services KPI Data Templates e.g. Sickness

Staff Sickness levels against Target

Target: 3.54%

Current Performance against Target or Standard

Trust Position	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	5.25	5.22	5.21	5.28	5.28	5.29	5.10	4.84	4.85	4.91	5.01	5.09	5.23	5.36	5.48
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis
The SPC chart shows a deteriorating trend over the last 8 months with the overall average 5.2% sickness level remains higher than the 3.54% target

SLT Lead: VCC Director

In Month Position

The **'what, where and when'** of the KPI performance is already shown in the table and graph opposite i.e. **What** the %'s are; **Where** it happened and **When** performance improved/declined. There is no need to repeat this.

Describe here more the **'why, how and who'** underneath the figures i.e. **Why** performance happened; **How** we will improve and **Who** is the Lead responsible i.e. this is about what changes are needed to the way the system operates, to ensure it routinely achieves the target

Service Improvement Actions

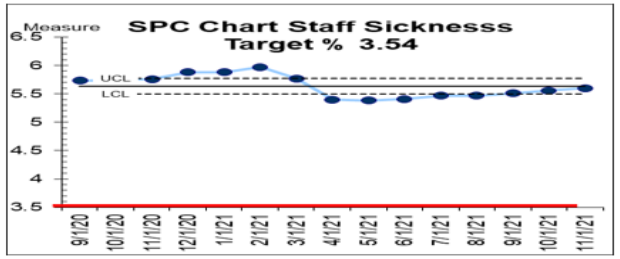
Actions:	Timescale:	Lead:
• Action one	XX/XX/XX	AN Other
• Action two	XX/XX/XX	AN Other
• Action three	XX/XX/XX	AN Other

Staff Sickness levels against Target

Target: 3.54%

Current Performance against Target or Standard

VCC Position	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	5.73	5.74	5.76	5.88	5.88	5.97	5.77	5.40	5.38	5.41	5.47	5.47	5.51	5.56	5.60
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis
The SPC chart shows a consistent deterioration over the last 8 months, with the average 5.6% sickness level remaining higher than the 3.54% target

SLT Lead: VCC Director

In Month Position

The **'what, where and when'** of the KPI performance is already shown in the table and graph opposite i.e. **What** the %'s are; **Where** it happened and **When** performance improved/declined. There is no need to repeat this.

Describe here the **'why, how and who'** underneath the figures i.e. **Why** performance happened; **How** we will improve and **Who** is responsible

System Capability and SPC Chart Trend Analysis

'What, where and when' as above, but for the ongoing system

'Why, how and who' as above, but for the ongoing system
i.e. this is about what changes are needed to the way the system operates, to ensure it routinely achieves the target

Service Improvement Actions

Actions:	Timescale:	Lead:
• Action one	XX/XX/XX	AN Other
• Action two	XX/XX/XX	AN Other
• Action three	XX/XX/XX	AN Other

Staff Sickness levels against Target

Target: 3.54%

Current Performance against Target or Standard

WBS Position	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	My 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Actual %	4.53	4.43	4.43	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.81	5.10	5.41	5.69	5.95
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

SPC Chart Analysis
The SPC chart shows a deteriorating trend over the last 8 months with the overall average 4.54% sickness level remains higher than the 3.54% target

SLT Lead: VCC Director

Performance Trends and System Capability

The **'what, where and when'** of the KPI performance is already shown in the table and graph opposite i.e. **What** the %'s are; **Where** it happened and **When** performance improved/declined. There is no need to repeat this.

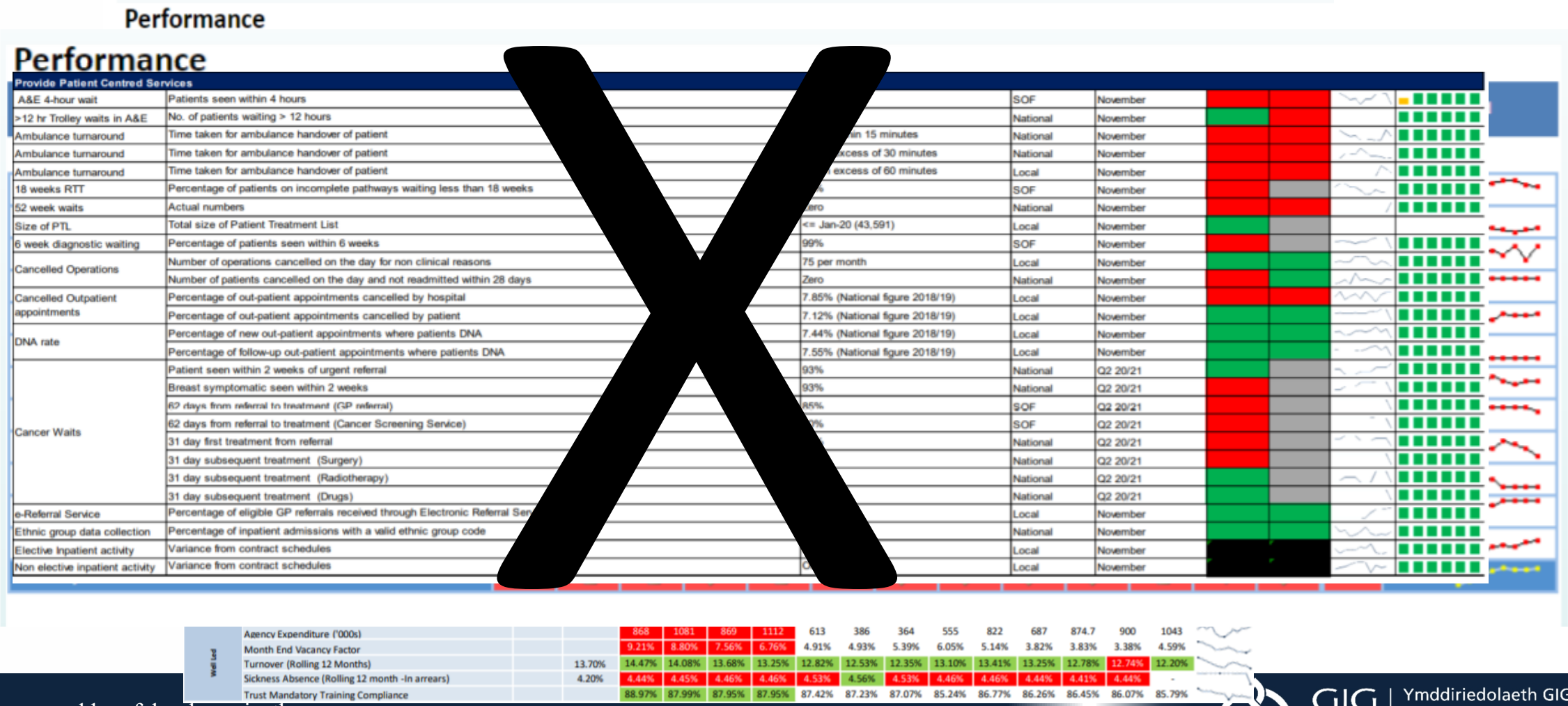
Describe here more the **'why, how and who'** underneath the figures i.e. **Why** performance happened; **How** we will improve and **Who** is the Lead responsible i.e. this is about what changes are needed to the way the system operates, to ensure it routinely achieves the target

Service Improvement Actions

Actions:	Timescale:	Lead:
• Action one	XX/XX/XX	AN Other
• Action two	XX/XX/XX	AN Other
• Action three	XX/XX/XX	AN Other

4 – Performance and Assurance: Escalation

Our Mission……



Performance

Performance

Provide Patient Centred Services					
A&E 4-hour wait	Patients seen within 4 hours		SOF	November	
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours		National	November	
Ambulance turnaround	Time taken for ambulance handover of patient	in 15 minutes	National	November	
Ambulance turnaround	Time taken for ambulance handover of patient	excess of 30 minutes	National	November	
Ambulance turnaround	Time taken for ambulance handover of patient	excess of 60 minutes	Local	November	
18 weeks RTT	Percentage of patients on incomplete pathways waiting less than 18 weeks		SOF	November	
52 week waits	Actual numbers	ero	National	November	
Size of PTL	Total size of Patient Treatment List	<= Jan-20 (43,591)	Local	November	
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	November	
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	November	
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	National	November	
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	7.85% (National figure 2018/19)	Local	November	
	Percentage of out-patient appointments cancelled by patient	7.12% (National figure 2018/19)	Local	November	
DNA rate	Percentage of new out-patient appointments where patients DNA	7.44% (National figure 2018/19)	Local	November	
	Percentage of follow-up out-patient appointments where patients DNA	7.55% (National figure 2018/19)	Local	November	
Cancer Waits	Patient seen within 2 weeks of urgent referral	93%	National	Q2 20/21	
	Breast symptomatic seen within 2 weeks	93%	National	Q2 20/21	
	62 days from referral to treatment (GP referral)	85%	SOF	Q2 20/21	
	62 days from referral to treatment (Cancer Screening Service)	%	SOF	Q2 20/21	
	31 day first treatment from referral		National	Q2 20/21	
	31 day subsequent treatment (Surgery)		National	Q2 20/21	
	31 day subsequent treatment (Radiotherapy)		National	Q2 20/21	
	31 day subsequent treatment (Drugs)		National	Q2 20/21	
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Ser		Local	November	
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code		National	November	
Elective Inpatient activity	Variance from contract schedules		Local	November	
Non elective inpatient activity	Variance from contract schedules		Local	November	

Well Led															
	Agency Expenditure ('000s)			868	1081	869	1112	613	386	364	555	822	687	874.7	900	1043
	Month End Vacancy Factor			9.21%	8.80%	7.56%	6.76%	4.91%	4.93%	5.39%	6.05%	5.14%	3.82%	3.83%	3.38%	4.59%
	Turnover (Rolling 12 Months)	13.70%		14.47%	14.08%	13.68%	13.25%	12.82%	12.53%	12.35%	13.10%	13.41%	13.25%	12.78%	12.74%	12.20%
	Sickness Absence (Rolling 12 month -In arrears)	4.20%		4.44%	4.45%	4.46%	4.46%	4.53%	4.56%	4.53%	4.46%	4.46%	4.44%	4.41%	4.44%	-
	Trust Mandatory Training Compliance			88.97%	87.99%	87.95%	87.95%	87.42%	87.23%	87.07%	85.24%	86.77%	86.26%	86.45%	86.07%	85.79%

Our Mission

a slight decrease fr 5.25% t .23%

slightly deteriorated from 65.96 June mpared to 64.60% in July.

deteriorated from 81 in June to 81.14% in July.

deteriorated from 4.54% June t 17% in July.

performance deteriorated from 84.67% in June to 81.12% in July.

Where We Are Now……

Appendix 1

Safety & Quality Dashboard — Mar 2018

CQC Domain	Indicator	Previous Period	Previous Value	Latest Period	Latest Value	Difference	Trend over previous period	Trend - APR 2017 onwards	2017/18 Total / 2017/18 Average
SAFE	Patient Falls - Month Total (In-hospital)	January 2018	113	February 2018	120	7	▲		1353
	Patient Fall NO Injury	January 2018	81	February 2018	87	6	▲		1008
	Patient Fall Injury NO Fracture	January 2018	29	February 2018	32	3	▲		320
	Patient Fall FRACTURE	January 2018	3	February 2018	1	-2	▼		25
	Pressure Ulcers - Month Total (In-hospital)	December 2017	28	January 2018	26	-2	▼		216
	Pressure Ulcers - Grade 1	December 2017	2	January 2018	4	2	▲		36
	Pressure Ulcers - Grade 2	December 2017	22	January 2018	19	-3	▼		162
	Pressure Ulcers - Grade 3	December 2017	3	January 2018	2	-1	▼		16
	Pressure Ulcers - Grade 4	December 2017	1	January 2018	1	0	◄		2
	Safety Thermometer - Trust Harm Free Care	January 2018	98.64%	February 2018	97.30%	-1.34%	▼		98.30%
	Safety Thermometer - Trust New Harm	January 2018	1.36%	February 2018	2.70%	1.34%	▲		1.70%
	Safety Thermometer - In-hospital Harm Free Care	January 2018	97.13%	February 2018	93.75%	-3.38%	▼		97.32%
	Safety Thermometer - In-hospital New Harm	January 2018	2.87%	February 2018	6.25%	3.38%	▲		2.68%
	Safety Thermometer - Out of hospital Harm Free Care	January 2018	99.59%	February 2018	99.58%	-0.01%	▼		98.99%
	Safety Thermometer - Out of hospital New Harm	January 2018	0.41%	February 2018	0.42%	0.01%	▲		1.01%
	Nurse Events	January 2018	0	February 2018	0	0	◄		2
	Trust Compliance with National Safety Alerts	January 2018	100%	February 2018	100%	0.00%	◄		
	Clostridium difficile (C diff)	January 2018	3	February 2018	2	-1	▼		
	Methicillin-Resistant Staphylococcus Aureus (MRSA)	January 2018	0	February 2018	1	1	▲		
	Methicillin-Sensitive Staphylococcus Aureus (MSSA)	January 2018	1	February 2018	2	1	▲		
	Escherichia Coli (E.coli)	January 2018	5	February 2018	1	-4	▼		
	Klebsiella species bacteraemia (Klep sp)	January 2018	6	February 2018	1	-5	▼		
	Pseudomonas aeruginosa bacteraemia (Ps a)	January 2018	1	February 2018	0	-1	▼		
	Trust Wide Hand Hygiene Compliance (%)	January 2018	97.00%	February 2018	97.00%	0.00%	◄		
	SPEQS (Staff, Patient Experience and Quality Standards) - SAFE	January 2018	96.02%	February 2018	93.20%	-2.82%	▼		
CARING	Total - Friends and Family Test - Would Recommend	January 2018	95.36%	February 2018	95.76%	0.40%	▲		
	Total - Friends and Family Test - Wouldn't Recommend	January 2018	1.97%	February 2018	0.85%	-0.22%	▼		
	In-patient - Friends and Family Test - Would Recommend	January 2018	94.30%	February 2018	94.76%	0.46%	▲		
	In-patient - Friends and Family Test - Wouldn't Recommend	January 2018	3.82%	February 2018	1.85%	-1.97%	▼		
	Emergency Care - Friends and Family Test - Would Recommend	January 2018	93.27%	February 2018	95.73%	2.46%	▲		
	Emergency Care - Friends and Family Test - Wouldn't Recommend	January 2018	2.40%	February 2018	0.61%	-1.79%	▼		
	Maternity - Friends and Family Test - Would Recommend	January 2018	96.97%	February 2018	98.01%	1.04%	▲		
	Maternity - Friends and Family Test - Wouldn't Recommend	January 2018	0.43%	February 2018	0.00%	-0.43%	▼		
	Out-patients - Friends and Family Test - Would Recommend	January 2018	94.22%	February 2018	94.46%	0.24%	▲		
	Out-patients - Friends and Family Test - Wouldn't Recommend	January 2018	1.07%	February 2018	2.22%	1.15%	▲		
	Day Case Unit - Friends and Family Test - Would Recommend	January 2018	99.13%	February 2018	97.38%	-1.76%	▼		
	Day Case Unit - Friends and Family Test - Wouldn't Recommend	January 2018	0.14%	February 2018	0.00%	-0.14%	▼		
	Radiology - Friends and Family Test - Would Recommend	January 2018	98.40%	February 2018	98.73%	0.88%	▲		
	Radiology - Friends and Family Test - Wouldn't Recommend	January 2018	1.17%	February 2018	1.15%	-0.02%	▼		
	Community Clinics - Friends and Family Test - Would Recommend	January 2018	100.00%	February 2018	98.65%	-1.35%	▼		
	Community Clinics - Friends and Family Test - Wouldn't Recommend	January 2018	0.00%	February 2018	0.00%	0.00%	◄		
	Community Dental - Friends and Family Test - Would Recommend	January 2018	100.00%	February 2018	97.14%	-2.86%	▼		
	Community Dental - Friends and Family Test - Wouldn't Recommend	January 2018	0.00%	February 2018	0.00%	0.00%	◄		
	SPEQS (Staff, Patient Experience and Quality Standards) - CARING	January 2018	95.26%	February 2018	97.79%	2.53%	▲		
EFFECTIVE	Hospital Standardised Mortality Ratio (HSMR)	December 2016 - November 2017	100.04	January 2017 - December 2017	101.32	1.29	▲		
	Crude Mortality Ratio - HSMR	December 2016 - November 2017	3.39%	January 2017 - December 2017	3.44%	0.05%	▲		
	Summary Hospital-Level Mortality Indicator (SHMI)	June 2016 - May 2017	109.07	July 2016 - June 2017	108.01	-1.06	▼		
	Crude Mortality Ratio - SHMI	June 2016 - May 2017	3.52%	July 2016 - June 2017	3.48%	-0.03%	▼		
	SPEQS (Staff, Patient Experience and Quality Standards) - EFFECTIVE	January 2018	92.52%	February 2018	0.00%	-92.52%	▼		
RESPONSIVE	Trust Complaints - Month Total	January 2018	96	February 2018	79	-17	▼		
	Stage 1 Complaints - Informal	January 2018	70	February 2018	50	-20	▼		
	Stage 2 Complaints - Formal Meeting	January 2018	11	February 2018	10	-1	▼		
	Stage 3 Complaints - Formal Chief Executive Letter	January 2018	15	February 2018	19	4	▲		
	25 Day Compliance Rate	December 2017	100%	January 2018	82%	-18.00%	▼		
	SPEQS (Staff, Patient Experience and Quality Standards) - RESPONSIVE	January 2018	92.52%	February 2018	94.51%	1.98%	▲		
WELL-LED	DAY – Nursing Workforce Average Fill Rate - Registered Nurses/Midwives	January 2018	81.03%	February 2018	82.04%	1.01%	▲		
	NIGHT - Nursing Workforce Average Fill Rate - Registered Nurses/Midwives	January 2018	93.81%	February 2018	92.17%	-1.63%	▼		
	DAY – Nursing Workforce Average Fill Rate - Care Staff	January 2018	101.23%	February 2018	99.91%	-1.32%	▼		
	NIGHT - Nursing Workforce Average Fill Rate- Care Staff	January 2018	123.13%	February 2018	129.22%	6.10%	▲		
	SPEQS (Staff, Patient Experience and Quality Standards) - WELL-LED	January 2018	95.05%	February 2018	87.50%	-7.55%	▼		

2. TRUST PERFORMANCE OVERVIEW

	Indicator	Objective	Director	Target	Set By	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	17/18	18/19	19/20
Safe	Falls per 1000 occupied bed days resulting in Harm	Patients	LM	<=0.90	QEH	0.08	0.00	0.00	0.00	0.08	0.17	0.08	0.18	0.33	0.09	0.00	0.17	0.24	0.07	0.09	0.12
	Eligible patients having Venous Thromboembolism (VTE) risk assessment	Patients	LM	>= 97.24%	QEH	97.45%	97.28%	97.29%	97.36%	97.57%	97.41%	97.29%	97.36%	97.44%	97.45%	97.31%	97.39%	Data TBC in arrears	97.10%	97.41%	97.38%
	Harm-free QEH Care	Patients	LM	>= 95%	QEH	96.40%	97.22%	97.66%	97.49%	98.77%	98.46%	98.62%	99.18%	96.08%	98.29%	99.54%	98.14%	98.82%	96.84%	97.73%	98.70%
	Never Events	Patients	FS	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0
	Serious Incidents (OCCURRED IN MONTH)	Patients	FS	0	Nat	1	5	3	3	4	7	6	4	9	3	3	7	5	29	54	18
	Serious Incidents (DECLARED IN MONTH)	Patients	FS	0	Nat	4	1	1	4	3	8	3	8	7	6	4	9	6			25
	Patient safety alerts not completed by deadline	Patients	FS	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Clostridium difficile (QEH acquired)	Patients	LM	4	Nat	4	6	1	1	3	2	0	1	0	2	3	4	3	48	22	12
	Clostridium difficile per 100k occupied bed days (rolling 12 months)	Patients	LM	<= 17.6	Nat	28.2	30.3	27.7	23.6	23.0	23.8	21.8	19.3	15.3	14.7	16.2	19.0	18.2	32.4	15.3	18.2
	MRSA bacteraemia (QEH acquired)	Patients	LM	0	Nat	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
	MRSA bacteraemia per 10k occupied bed days (rolling 12 months)	Patients	LM	0.0		1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.4	0.0	0.0	0.0	0.0	0.0	1.4	0.0
	Safe staffing levels (overall fill rate)	Patients	LM	>= 80%	Nat	95.6%	93.5%	95.2%	98.7%	98.1%	98.4%	102.6%	101.2%	111.0%	103.3%	103.8%	97.3%	95.5%		98.8%	99.0%
	No. of wards below 80% fill rate	Patients	LM	0	Nat	0	1	0	0	0	0	0	0	0	0	0	0	1		1	1
	Cleanliness Scores - very high-risk areas	Places	LM	>= 100%	Nat	94.71%	93.87%	95.45%	95.10%	94.59%	95.71%	94.60%	95.82%	95.48%	95.63%	95.88%	98.38%	96.63%		95.23%	96.63%
	Cleanliness Scores - high-risk areas	Places	LM	>= 100%	Nat	93.78%	93.80%	93.91%	95.29%	96.08%	93.94%	95.25%	96.03%	95.89%	94.41%	95.94%	97.59%	95.59%		94.88%	95.88%
	Cleanliness Scores - significant-risk areas	Places	LM	>= 100%	Nat	90.88%	92.20%	93.06%	92.85%	92.17%	88.11%	92.10%	92.62%	93.59%	94.19%	94.67%	96.22%	94.64%		91.48%	94.93%
	Cleanliness Scores - low-risk areas	Places	LM	>= 100%	Nat	89.38%	84.52%	90.56%	88.40%	94.43%	0.00%	92.03%	90.01%	96.72%	92.33%	95.59%	88.00%	93.57%		83.24%	92.35%
	No. of cleanliness audits complete	Places	LM	37		46	34	29	45	35	31	47	35	34	44	36	35	46		435	161
Effective	SHMI (Trust Level - Rolling 12 Mth position, 6 mths in arrears)	Patients	FS	Not higher than expected	QEH			99.56			99.91		6 months in arrears								
	Crude HSMR Mortality (Trust Level - Rolling 12 Mth position, 3 mths in arrears)	Patients	FS	-		3.53	3.46	3.43	3.36	3.35	3.25	3.14	3.09	3.02	Latest Data not available	3 months in arrears			3.60		
	HSMR (basket of 56 diagnosis groups) (Trust Level - Rolling 12 Mth position, 3 months in arrears)	Patients	FS	Not higher than expected	QEH	106.5	106.7	106.9	105.8	105.8	103.2	101.2	100.5	101.5					104.94		
	WEEKEND HSMR (basket of 56 diagnosis groups) (Trust Level - Rolling 12 Mth position, 3 months in arrears)	Patients	FS	Not higher than expected	QEH	115.0	114.4	115.3	116.4	114.7	114.5	112.4	109.0	107.4					111.35		
	Rate per 1000 admissions of inpatient cardiac arrests	Patients	FS	< 2.0	QEH	1.65	1.39	1.44	1.31	1.02	2.05	0.90	1.91	0.40	1.70	1.37	0.53	0.72	1.55	1.34	1.08
	Total C Section Rate	Patients	FS	< 25.00%	QEH	34.39%	27.81%	41.71%	30.77%	30.91%	35.63%	32.18%	34.36%	31.61%	31.93%	29.52%	30.72%		28.87%	33.47%	30.72%
	Stillbirth Rate (per 1000 births/stillbirths - Rolling 12 Mths)	Patients	FS	< 3.73	QEH	3.21	3.24	4.17	3.76	3.91	3.30	3.29	1.88	2.32	1.88	1.88	2.84	1 month in arrears	2.71	2.32	3.91
	Neonatal Deaths Rate (per 1000 livebirths - Rolling 12 Mths)	Patients	FS	< 1.06	QEH	0.46	0.46	0.93	0.94	1.90	2.36	2.36	2.82	2.79	2.82	2.83	3.32		0.90	2.79	1.96
	Extended Perinatal Deaths Rate (per 1000 births/stillbirths - Rolling 12 Mths)	Patients	FS	< 4.79	QEH	3.67	3.70	5.09	4.79	5.20	5.66	5.63	4.69	5.10	4.69	4.70	6.15		3.61	5.10	5.86
	% "Term" admissions to the NNU	Patients	FS	3.0%	QEH	Data not available prior to Apr 2019									6.5%	10.3%	5.7%	4.7%			6.7%
	% "Avoidable Term" admissions to the NNU	Patients	FS	0.0%	QEH										36.4%	16.7%	30.0%	9.1%			22.0%
	Maternal Deaths	Patients	FS	0	QEH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	National Clinical Audits participation rate	Patients	FS	=100%	QEH													97.5%	95%	95%	97.5%
	No. of patients recruited in NIHR studies	Patients	FS	>600 Annually	QEH	74	111	64	67	123	51	37	153	77	37	29	59	29		954	154
Caring	Same Sex accommodation standard breaches	Patients	LM	0	Nat	16	8	9	8	14	2	7	11	4	6	5	3	7	62	93	21
	No. of Complaints (Clinical & Non-Clinical)	Patients	LM	<= 20	QEH	36	41	41	36	32	27	41	37	38	34	47	24	38	362	421	143
	Complaints (rate as proportion of activity)	Patients	LM		QEH	0.10%	0.12%	0.12%	0.09%	0.08%	0.09%	0.11%	0.11%	0.11%	0.09%	0.12%	0.07%	0.10%		0.10%	0.10%
	% Complaints responded to within the national standard of six months from receipt of the complaint	Patients	LM	100%	Nat	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%		99.8%	98.8%
	% Complaints responded to within 30 days from receipt of the complaint	Patients	LM	>=90%	QEH	66.67%	71.88%	36.11%	46.34%	54.17%	33.33%	57.14%	46.43%	36.17%	6.90%	21.28%	9.76%	25.58%		41.36%	16.86%
	Reopened complaints (% of total complaints)	Patients	LM	<=15%	QEH	0.00%	0.00%	2.44%	0.00%	3.13%	11.11%	0.00%	0.00%	0.00%	2.94%	6.38%	20.83%	10.53%		1.64%	9.09%
	%eligible patients who have dementia case find applied	Patients	LM	>=90.00%		41.20%	46.32%	40.48%	38.76%	46.90%	45.80%	45.79%	44.66%	43.54%	48.94%	51.46%	36.00%	Data TBC in arrears	60.97%	44.09%	50.17%
	Friends & Family (Inpatients & Daycases)	Patients	LM	>=95%	QEH	95.48%	95.01%	95.50%	95.15%	96.15%	95.17%	95.05%	95.03%	96.21%	97.01%	96.73%	95.80%	96.35%	95.53%	95.53%	95.96%
	Sample Size: Friends & Family (Inpatients & Daycases)	Patients	LM	>=30%	QEH	30.36%	34.62%	34.97%	31.47%	33.05%	28.58%	33.67%	37.26%	37.83%	30.17%	36.67%	21.20%	31.31%	30.33%	33.21%	32.38%
	Friends & Family (Accident & Emergency)	Patients	LM	>=95%	QEH	93.15%	93.21%	90.94%	89.42%	89.86%	88.94%	94.32%	95.32%	90.57%	93.25%	94.82%	92.68%	90.93%	93.12%	91.16%	93.03%
	Sample Size: Friends & Family (Accident & Emergency)	Patients	LM	>=20%	QEH	14.65%	12.96%	8.04%	21.32%	20.81%	14.60%	10.20%	11.59%	11.04%	11.55%	11.70%	7.67%	9.81%	16.98%	13.79%	10.16%
	Friends & Family (Outpatients)	Patients	LM	>=95%	QEH	97.10%	97.72%	96.65%	96.03%	96.79%	97.40%	97.07%	96.88%	97.35%	96.98%	96.17%	97.38%	95.77%	96.78%	97.05%	96.54%
	Sample Size: Friends & Family (Outpatients)	Patients	LM		QEH	6.61%	6.05%	5.88%	6.88%	6.19%	5.73%	7.18%	5.63%	6.82%	6.14%	6.15%	6.13%	7.04%	5.41%	6.42%	6.37%
	Friends & Family (Maternity)	Patients	LM	>=95%	QEH	95.12%	100.00%	100.00%	100.00%	94.74%	94.12%	96.67%	100.00%	93.65%	96.94%	100.00%	100.00%	96.83%	96.90%	96.57%	98.62%
	Sample Size: Friends & Family (Maternity)	Patients	LM	>=15%	QEH	21.24%	14.71%	11.58%	22.94%	23.31%	20.12%	17.05%	21.64%	34.62%	31.68%	35.71%	26.67%	27.63%	15.20%	21.97%	30.19%

The Importance of Focus

Safety & Quality Dashboard		Mar 2018							
CQC Domain	Indicator	Previous Period	Previous Value	Latest Period	Latest Value	Difference	Trend over previous period	Trend - APR 2017 onwards	2017/18 Total / 2017/18 Average
	Emergency Care - Friends and Family Test - Would Recommend	January 2018	93.27%	February 2018	95.73%	2.46%	▲		94.32%

One month trend…….

Is an increase from 95.36% to 95.76% important or distracting narrative?

Caring

7 Family and Friends Test (FFT) (data up to February 2018)

7.2 The Trusts 'Would Recommend' for Friends and Family returns *increased* to 95.76% for February 2018 from 95.36% in January 2018. The percentage of patients who stated they 'Wouldn't Recommend' *decreased* to 0.85% in February 2018 from 1.07% in January 2018.


J
Q
K

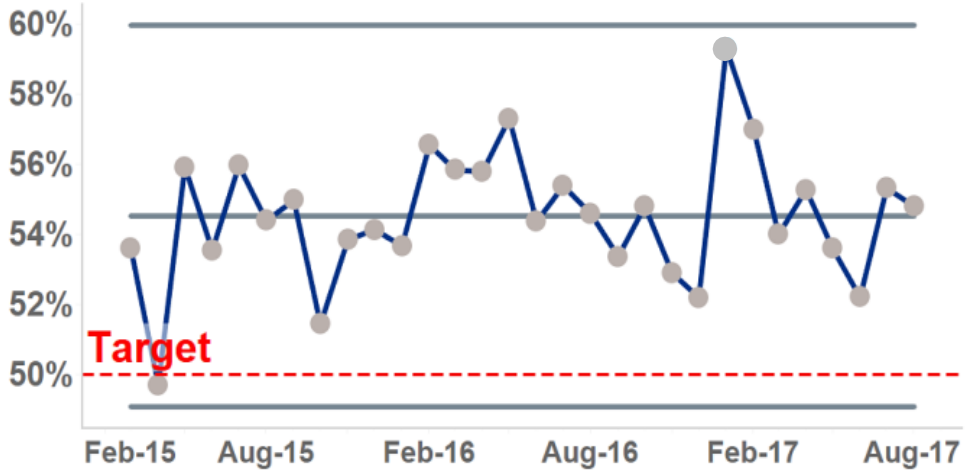
Specialty RTT Performance

Specialty Performance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend	Trend
Cardiology	94.7%	92.0%	92.3%	92.3%	93.0%	92.7%	94.3%	93.7%	94.4%	↑	0.7%
Dermatology	98.4%	98.1%	98.2%	95.8%	89.3%	85.7%	90.3%	90.8%	92.1%	↑	1.3%
Ear, Nose & Throat	92.0%	92.9%	92.3%	91.8%	90.0%	89.1%	88.4%	88.4%	87.0%	↓	-1.4%
Gastroenterology	86.5%	87.7%	86.3%	87.7%	87.7%	86.7%	85.8%	85.5%	86.1%	↑	0.6%
General Medicine	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%		0.0%
General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%
Geriatric Medicine	98.9%	98.9%	98.0%	96.3%	94.4%	96.9%	98.0%	99.1%	98.6%	↓	-0.5%
Gynaecology	87.0%	87.8%	89.3%	89.3%	88.9%	87.9%	87.9%	87.1%	85.3%	↓	-1.8%
Neurology	92.1%	92.1%	92.8%	89.2%	83.2%	84.7%	86.3%	87.6%	86.7%	↓	-0.9%
Ophthalmology	81.2%	84.5%	84.9%	86.3%	89.2%	89.3%	90.4%	90.0%	87.6%	↓	-2.4%
Oral Surgery	78.8%	81.8%	83.6%	82.6%	81.8%	83.9%	84.6%	85.7%	83.5%	↓	-2.2%
Orthopaedics	88.6%	92.0%	91.4%	89.3%	87.4%	87.1%	85.5%	83.6%	83.2%	↓	-0.4%
Other	87.9%	88.4%	90.0%	89.7%	89.8%	89.6%	91.0%	91.5%	90.4%	↓	-1.1%
Plastic Surgery	82.2%	84.7%	87.6%	89.2%	88.7%	88.2%	88.6%	87.9%	84.7%	↓	-3.2%
Respiratory Medicine	79.3%	83.4%	87.5%	89.8%	92.2%	93.2%	92.6%	92.2%	86.1%	↓	-6.1%
Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%
Urology	85.4%	87.5%	88.7%	89.9%	91.5%	91.4%	92.0%	92.2%	90.6%	↓	-1.6%
TRUST	86.1%	87.7%	88.7%	88.7%	88.3%	87.9%	88.7%	88.7%	87.4%	↓	-1.3%

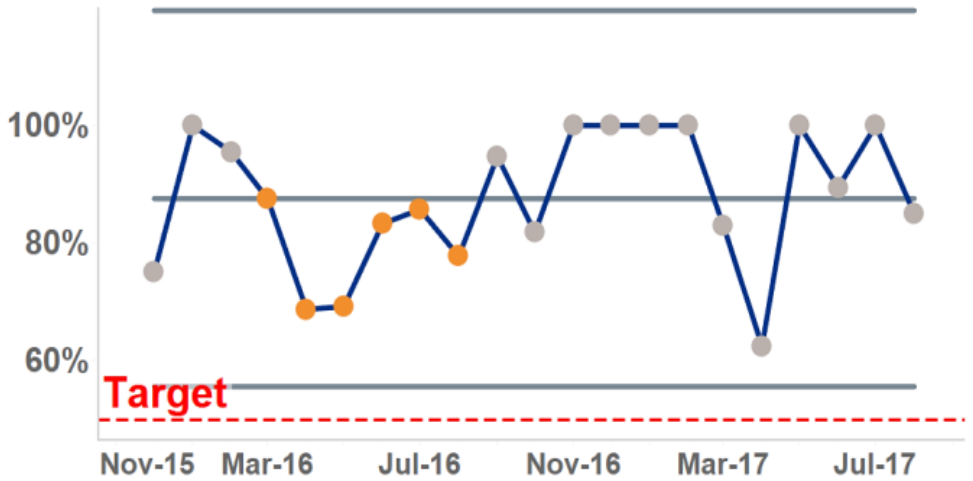
Improving Access to Psychological Therapies – performance against target

Metric	Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
IAPT Treatment 18 Weeks	95%	100.0%	99.5%	99.9%	99.8%	99.4%	99.7%	99.6%	99.7%
IAPT Treatment 6 Weeks	75%	86%	84%	83%	81%	75%	80%	81%	81%
IAPT Recovery Rate	50%	59%	57%	54%	55%	54%	52%	55%	55%
EIS First Episode Psychosis	50%	100%	100%	83%	63%	100%	89%	100%	85%

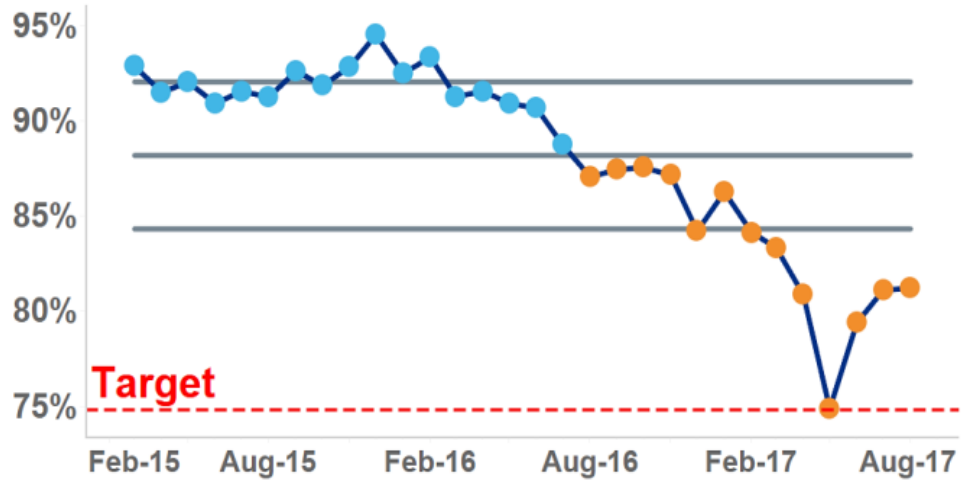
IAPT Recovery Rate



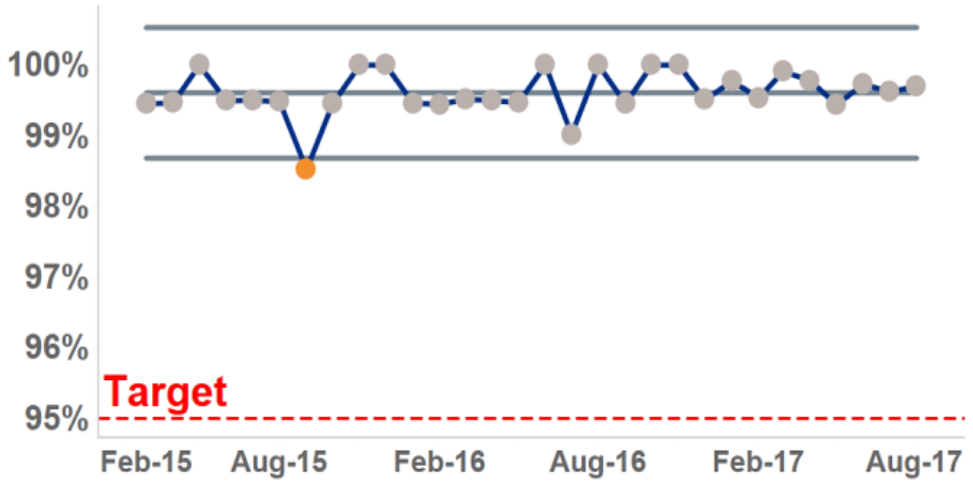
EIS First Episode Psychosis



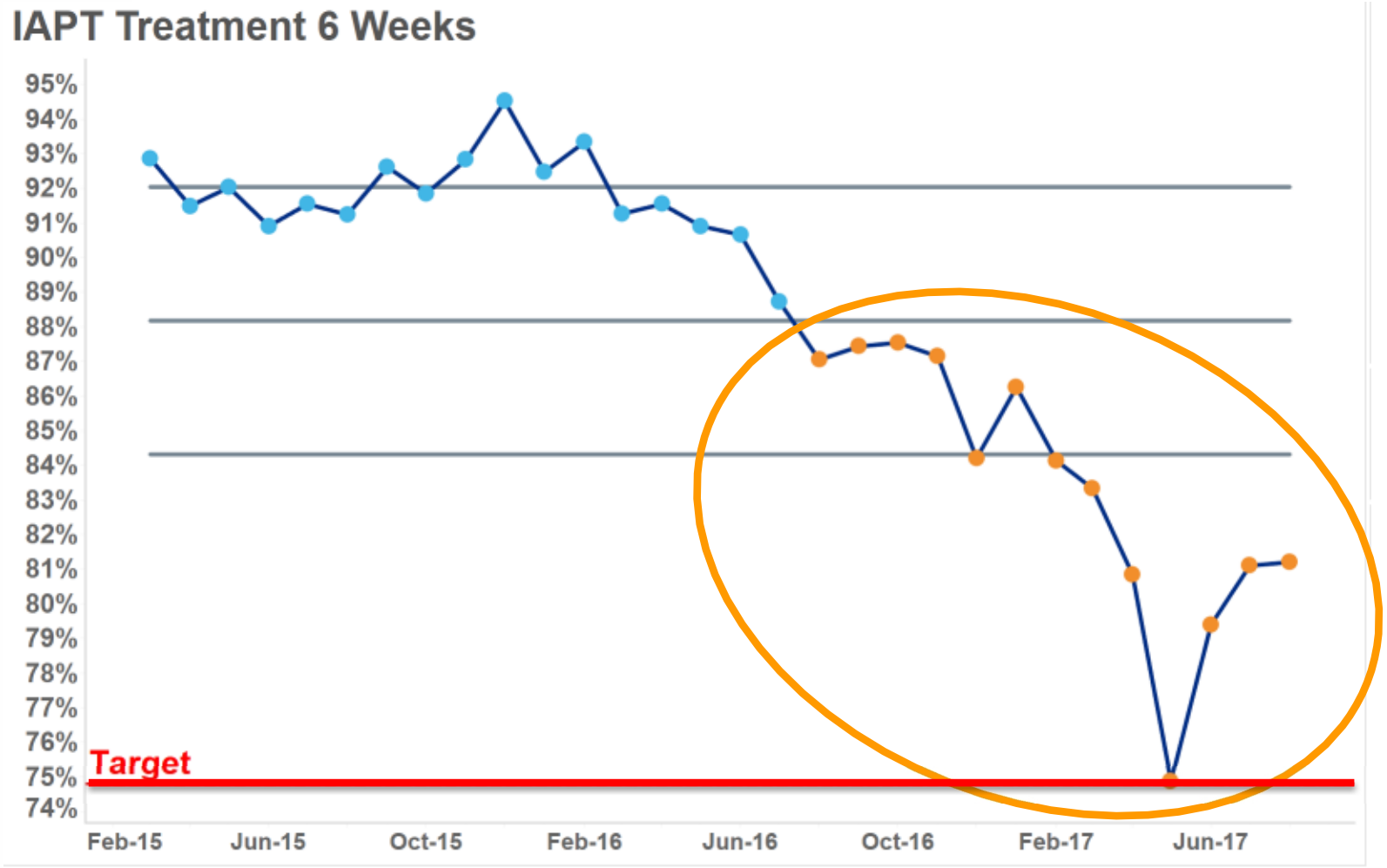
IAPT Treatment 6 Weeks



IAPT Treatment 18 Weeks



Did Green Provide True Assurance?



SPC charts (Statistical Process Control Charts) are used to measure changes in data over time. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes worth investigating (Extreme values) from normal variations.

The charts consist of.

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.

- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.

- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are ‘extreme values’ and is not within the expected ‘normal variation’.

- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.

- Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

Performance and escalation: looking for patterns and trends

- Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

Identifying patterns

- Normal variation- (common cause) fluctuations in data points that sit between the upper and lower control limits that do not reach the criteria for a Trend.

- Extreme values (special cause) any value on the line graph that falls outside the control limits.

- These are very unlikely to occur- and where they do, there is likely a reason or handful of reasons outside the control of the process behind the extreme value.

- A Trend: a trend may be identified where there are 7 consecutive points in either a pattern that could be; a downward trend, and upward trend, or string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome.

Thresholds for Escalation

Its an area we are still working on with the process control charts helping us identify:

- escalation of a process:

a. normal cause variation i.e. the process is not consistently able to produce the level of performance we require e.g. A&E performance
b. special cause variation i.e. a ‘one off’ cause e.g. covid pandemic; hospital fire/evacuation

Discussing with Delivery Unit about use of SPC in terms of escalation. General expectation that it will be by decision of responsible group based on patterns/trends and variation body e.g. SLT; EMB; QSP

5 – Who’s Been Involved?

Who's Been Involved?

- Meetings held with circa 40 members of staff out of circa 50 members of staff who contribute to the PMF (2 future meetings during w/c 27th June)
- Individual meetings held with Independent Members who attend QSP
- Process, approach and timescales presented to, and endorsed by, SLTs, EMB and SDC
- Update meetings held with CHC (Stephen Allen)

Feedback from Meetings

Meetings yet to be completed……but so far:

- Positive feedback on summary matrix, hyperlinks, scorecards and supporting data templates
- Agreements that we need to include an executive summary highlighting key performance issues / successes
- Agreement that the refresh of the PMF provides a good opportunity to review / replace existing KPIs with more meaningful measures which will in turn help to staff to manage performance
- Agreement that we need to improve the narrative included within the reports e.g. don't repeat what is included within the date but explain cause, impact and actions
- Need to highlight good performance as well as areas for improvement / under performance
- Need to agree consistent process for escalation – SLTs, EMB. QSP, TB
- Distribution curves would be useful to understand target compliance and extent of breaches

6 – Next Steps

PMF Development Timetable – completed elements

PMF Project Phase 1

- Trust-wide PMF (organisational level) and VCC and WBS PMF (service level) Scorecard reporting structures have been developed and discussed with Divisions and Trust-wide functions **(complete)**
- Simple supporting KPI Templates with enhanced graphics and SPC Charts have also been developed and discussed **(complete)**
- The new format KPI Templates encourage narratives that strike the correct balance between robust data analysis and explanations that are simple to understand and accessible to the general public **(complete)**
- VCC, WBS and Trust-wide KPIs have introduced new measures more related to patient, donor and business outcomes **(complete)**
- Performance Reports, based upon January 2022 data, have been trialed and tested for accuracy **(complete)**
- **Pilot: July 2022 and evaluate**
- **Finalise and implement Oct/Nov 2022**

STRATEGIC DEVELOPMENT COMMITTEE

MEMORANDUM OF UNDERSTANDING ON THE SUPPLY OF PLASMA FOR MEDICINES

DATE OF MEETING	(07/07/2022)

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item.

PREPARED BY	Peter Richardson, Head of Quality Assurance and Regulatory Compliance
PRESENTED BY	Alan Prosser, Director of WBS
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	
WBS	The Welsh Blood Service
IG	Immunoglobulin
MHRA	Medicines and Healthcare Products Regulatory Agency
NHSBT	NHS Blood and Transplant
NHSEI	NHS England and NHS Improvement

1. SITUATION/BACKGROUND

In response to the growing risk of shortages of Immunoglobulins (IG) the medicines and Healthcare Products Regulatory Agency (MHRA) lifted the ban on the use of plasma donated by UK residents for the manufacture of medicines by fractionation in February 2021. Since then the UK blood services have been reviewing their capability to increase collections of plasma for medicines.

NHS England and NHS Improvement (NHSEI), with the support of NHS Blood and Transplant (NHSBT), have engaged with the pharmaceutical industry to secure a contract for the fractionation of plasma into medicines. In parallel the UK devolved administrations and their respective blood services have been invited to join with NHSEI and NHSBT under a Memorandum of Understanding (MOU) to develop this contract.

The proposed MOU does not bind devolved administrations or blood services into any resulting contract, but will give each blood service an option to enter into a contract with the successful bidder on identical terms. This assumes that all UK blood services will adopt the operating model implied within the MOU.

The draft MOU is being finalised and we are currently awaiting clarification from Welsh Government on their position in relation to the proposed operating model. Once this is agreed, WBS/VUNHST will be able to review and sign the MOU to enable further engagement in the process and determine the governance and programme arrangements.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The contracting approach being proposed by NHS England and Improvement

NHS England issued contract notice for a UK Domestic Plasma Fractionation service on April 11th, 2022 noting the following:

"As regards Northern Ireland, Scotland and Wales, the respective Blood Services (represented by their hosting bodies where applicable) for each of the regions have expressed interest in this procurement. Therefore the Blood Services for each region (including their hosting bodies where applicable), the Devolved Administration for each region and the NHS providers in each region (as potential buyers of products derived from fractionation) are included by NHSE&I as Participating Authorities ("PAs") within this Contract*

Notice, as further defined in the tender documents.

This provides an option for each of the above bodies to be a party to the contractual arrangements that will result from this procurement (by entering into essentially identical but separate contracts, under the law and jurisdiction of the relevant region in each case), but does not bind them to do so."

- note- the governance arrangements for WBS/VUNHST are not a hosting arrangement and this has been clarified with NHSE&I who used this phrase to articulate general organisational arrangements for all services.

There are a range of confidential commercially sensitive documents that require the MOU to be signed prior to access is granted to Devolved Administrations. A meeting is planned to explore the procurement arrangements that would lead to the option outlined being enabled.

2.2 Benefits of collaboration with other UK Blood Services

By working collaboratively with the other UK blood services, Wales would be able to benefit from economies of scale and maximize the financial benefits from a fractionation contract. The significant workload involved in developing and validating processes can be mitigated if blood services work collaboratively. This will be further explored through procurement meetings on agreement of the final MOU.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Provision of safe UK derived plasma medicines for UK patients
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below: Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	To be considered if Wales agrees to participate in the procurement.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Governance/Legal position needs to be clarified
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Under discussion with Welsh Government

4. RECOMMENDATIONS

The Strategic Development Committee are asked to:

1) NOTE: the contract notice issued on 11th April 2022 and the potential for Wales to participate.
2) NOTE: the Welsh Government's Intention to sign the MOU to participate in discussions about a contract for a domestic fractionation service.
3) NOTE: Continued discussion between WBS and the Welsh Government with the aim of WBS/VUNHST signing the MOU.
4) NOTE: that following the agreement of the MOU appropriate governance arrangements will be put in place for formal agreement by VUNHST.

STRATEGIC DEVELOPMENT COMMITTEE

ADVANCED THERAPIES WALES UPDATE

DATE OF MEETING	7th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	(Andrew Owen, Advanced Therapies Programme Delivery Manager)
PRESENTED BY	(Cath O'Brien, Chief Operating Officer)
SMT SPONSOR APPROVED	(Cath O'Brien, Chief Operating Officer)

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB Shape	(22/06/2022)	NOTED

ACRONYMS	
ATW	Advanced Therapies Wales
ATMP	Advanced Therapy Medicinal Products
VUNHST	Velindre University NHS Trust

ATSoI	Advanced Therapies Statement of Intent
IMTP	Integrated Medium Term Plan
NICE	National Institute of Clinical Excellence
ATTC	Advanced Therapies Treatment Centres

1. SITUATION

The Advanced Therapies Wales (ATW) Programme was established in 2019 on behalf of the Welsh Government after the publication of their Advanced Therapies Statement of Intent (SOI). The Programme is part of the Precision Medicine initiative within the Health and Social Services Group. The SOI outlines the challenges, opportunities and actions necessary to develop a sustainable strategic approach to developing the ATMP sector in Wales. The Programme team is led and managed by the Velindre UNHS Trust and reports into VUNHST RD&I committee.

The ATW programme is tasked with supporting delivery of the SOI and to act as a resource centre providing sector expertise and domain knowledge.

Funding for the Programme is through an annual basis from Welsh Government as an ongoing initiative which is reviewed on an annual basis. The mechanism for the delivery of NICE approved ATMPs is funded through specific Welsh Government funding allocated to Welsh Health Specialised Services Committee. Currently, there is no direct funding identified for infrastructure and resources to support implementation in Wales and investments require the submission of a business case to Welsh Government.

The Covid Pandemic, which was declared by the World Health Organisation in February 2020, had a significant impact on the ATMP sector, with a decline in new products being assessed by the NICE and research projects commencing. This resulted in a significant element of the work of ATW being paused, however this has now been recommenced

However, in spite of the pandemic and the impact of these delays, the overall ATMP sector continued to grow. The Cell & Gene Therapy Catapult reported a 65% increase in UK ATMP investment in 2021 (£2.5bn in 2020 and £3.8bn in 2021) and a 20% growth in the number of ATMP clinical trials across the UK from the previous year.

This paper provides an oversight of the Advanced Therapies Wales Programme, anticipated changes to the structure going forward and the programme of work for 2022/23.

2. BACKGROUND

2.1 Statement of Intent

In 2019 Welsh Government produced its statement of intent (SOI) for ATMPs in Wales.

The SOI aims to:

- Provide a vision for a strategic approach to harness the benefits from emerging and transformative ATMPs.
- Create a sustainable platform to enable NHS Wales to provide patients with equitable access to emerging ATMPs.
- Explore how this sector can contribute to the objectives of the Welsh Government's A Healthier Wales: Our Plan for Health and Social Care in Wales Deliver our full potential in the international and UK development of ATMPs.
- Support strategic partnerships and collaboration between NHS Wales and academic and industry partners to harness the potential of ATMPs to improve health, well-being and prosperity for the people of Wales.

The SOI identified nine priority areas to be addressed in supporting a sustainable strategic approach to developing the ATMP sector in Wales.

Since its inception, the programme has worked in partnership with Health Boards, Academia, Research and Industry and has assisted in the development and implementation of a number of initiatives to promote the adoption of ATMPs in Wales, including exploring opportunities with research and clinical trials, and also when treatments likely to assessed by National Institute of Clinical Excellence (NICE).

2.2 MW-ATTTC

In 2018, three national Advanced Therapy Treatment Centres were established. Securing £11.9 million grant funding to deliver Phase 1 (2018 – 2022). Midlands–Wales ATTC, was a consortium jointly led by Velindre University NHS Trust (on behalf of NHS Wales) and University Hospitals Birmingham NHS Foundation Trust. This programme ran in parallel to ATW.

The initial 3 year programme was extended as a result of the pandemic and then closed 31/03/2022, due to the inability to secure further UK government funding. However, there is a hope that the Westminster Autumn spending review may identify funding to support further work. In the interim, the network established via the initiative continues to scope further projects and seek alternative funding. The legacy resources have been passed to other organisations for ongoing updating. The Programme lead from ATW will be maintain close links with the lead and a 'watching' brief.

2.3 Challenges for ATMPs in Wales

For a new emerging area such as advanced therapy development, there are a number of challenges. It is recognised that the current infrastructure in Wales is will require major investment to ensure delivery of ATMPs (both service delivery and clinical trials). The role for ATW is to help organisations identify the gaps in service need and potential solutions.

Clinical trials
The delivery of clinical trials requires enhanced infrastructure and collaborative and joint-working agreements, and supported by the necessary engaged, empowered and educated workforce. These are critical elements that will enable the sector to grow and develop and in turn will improve health, well-being and prosperity for the people of Wales.

NICE approved
For ATMPs which can be delivered through a single or multiple Local Health Boards in Wales, the challenge lies with understanding their 'organisational readiness', ensuring there is estate infrastructure, workforce, equipment and other facilities to support their delivery.

Funding
Whilst clinical trials are often funded through an industry sponsor, this tends to be for the lifespan of the study. In order to embed ATMPs into the NHS in Wales, we need to be able to look at how we financially support staff in roles as a programme transitions from a study into service delivery.

Whilst ATMPs which are NICE approved as funded via a £20m pot of money provided by Welsh Government and managed by WHSSC, this money is for the product and its

specific clinical delivery and does not necessarily cover the additional costs associated with service establishment e.g. infrastructure, regulatory requirements, training etc.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3. 1 Programme Activities 2021/22

Horizon Scanning

The ATW Programme has worked with colleagues in WHSSC, using data from a national horizon scanning group (based at NHS England) to feed into a comprehensive 'Horizon Scanning' database that centralises data from a number of sources. Following monthly publication of this data, it has been identified the impact this could have on NHS Wales.

Project Funding

In 2021/22, ATW identified programme funding for additional projects that would inform and enhance ATMP opportunities in Wales. These projects included:

- Developing cellular therapy manufacturing capability in Wales (Cardiff University): Generating virus-specific T-cells and mesenchymal stem cells for patient benefit.
- Gene therapy detailing the current position in Wales (Swansea University).
- Development of analogues for research Antibody-drug Conjugates (Swansea University).
- Research Lead/Nurse Support for Advanced Therapies Clinical Trials in Cardif Research Facility.
- Resource Support for the Athersys, Inc, MultiStem® Administration for Stroke Treatment and Enhanced Recovery Study (Cardiff Research Facility).
- Providing Resource for ATMP commercial trials at the BRAIN Unit, Cardiff.
- Exploration of real world data for future evaluation of the costs, consequences and budget impact of the treatment and management of Diffuse Large B Cell Lymphoma in NHS Wales.

AMTP Clinical Trials

The ATW Programme has supported clinical and research teams identify, consider and set up ATMP clinical trials. Through the programme's dedicated Clinical Trials Nurse, the programme has been able to offer resource and knowledge in the set up and recruitment for these trials. Working with Health & Care Research Wales, the ATW programme has set up set up a project group to identify new clinical trials available to Wales. The ATW programme now receives regular reports compiled by HCRW, and through their Industry Engagement Manager the programme is able to have open dialogue with companies looking for clinical trials sites.

3.2 Proposed Revised Governance and Delivery Structure

On establishment, Len Richards, the then Chief Executive Officer of C&VUHB, was appointed as the senior responsible Officer (SRO). This transferred to Suanne Rankin the new CEO for C&VUHB in February 2022.

In May 2022, the ATW programme team facilitated a workshop with key stakeholders to assess the current situation and review the programme structure and governance arrangements. Work has recently been undertaken to develop the existing governance and delivery structure to support a revised programme of work for 2022/23. The revised work programme in under development and expected to be agreed by the Programme Board in July 22, but core projects continue to be delivered while this work is undertaken.

The ATW programme structure will include two working groups that will support service deliver (Adoption of NICE Approved ATMPs Working Group) and all aspects of ATMP research (Research, Development and Innovation Working Group).

These changes to the ATW programme and the proposed workplan for 2022/23 will ensure that the programme remains relevant, avoids duplication and delivers against Welsh Government's ATMPSoI.

3.3 Current activity

The review and proposed changes in structure has given the programme as opportunity to review priorities for 2022/23 as the sector continues to mature, especially after the pandemic. A detailed workplan for 2022/23 is still in development and awaiting sign off from the Programme Board, and this will focus on supporting research and ensuring that NHS Wales organisations are ready for the introduction of new ATMPs.

3.4 Recruitment of Clinical Lead

The Programme is in the process of recruiting a Clinical Lead for ATMP which will allow greater engagement with NHS organisations, in particular with medical colleagues across health and academia. The role will provide clinical leadership within the Advanced Therapies Wales programme and support the Senior Responsible Officer (SRO) and Programme team in delivery the Welsh Government Statement of Intent for Advance therapeutic Medicinal Products for the population of Wales. It will be an integral part of the Programme leadership team.

Facilitating Clinical Trials

A key focus for the Research, Development and Innovation Working Group will be to support translational research and clinical trials. The ATW programme is currently offering continued support to facilitate a CART solid tumour clinical trial in collaboration with VUNHST and CVUHB. The programme is providing support to the project team identify a delivery pathway across the two organisations, including the identification of resources and roles/responsibilities.

Translational research

Activity has also started on the development of an Outline Business Case lead by Cardiff University and working in partnership with C&VUHB for the establishment of a centre of excellence to support advanced therapies in neurological conditions on the C&VUHB site.

Adoption of ATMPs

The programme of work for the Adoption of NICE Approved ATMPs Working Group will build on existing work with WHSSC to focus on scoping and implementing pathways and referral processes for specific NICE approved ATMPs, The Working Group will continue to use horizon scanning information to identify products and their likely timescale for NICE appraisal. Task and finish groups will be established to engage with service delivery organisations to implement regulatory and delivery requirements.

Networking, Engagement and communication

A communication and Engagement Working Group will also be established, supported by a communication and engagement plan. There will also be a review of the ATW website and the delivery of a communications workplan.

There is continued engagement with the ATTC network and the Cell and Gene Catapult to ensure that the ATW programme is linked in with UK wide ATMP activity, and there continues to be a successful partnership between the programme and the Life Science Hub Wales

The ATW programme has recently met with colleagues from the Clinical Research Facility in North Wales to establish their interest in ATMPs, specifically gene therapy and first in human clinical trials.

3.3 Risks

No significant risks identified at this stage

3.4 Financial Implications

An outline of costs for 2022/23 has been submitted to Welsh Government ahead of receiving a letter of confirmation for funding. Verbal confirmation has been received and we are awaiting funding letter.

4. 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.

5. RECOMMENDATION

The Committee are asked to **NOTE** the Advanced Therapies Wales update.

STRATEGIC DEVELOPMENT COMMITTEE

MIDLANDS AND WALES ADVANCED THERAPY TREATMENT CENTRE

DATE OF MEETING	7th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mrs. Debbie Bees
PRESENTED BY	Cath O'Brien – Chief Operating Officer
SMT SPONSOR APPROVED	Cath O'Brien – Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

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

ACRONYMS	
	ATMP – Advanced Therapy Medicinal Products MW-ATTC – Midlands and Wales Advanced Therapy Treatment Centre ATW – Advanced Therapies Wales

1. SITUATION

The MWATTC programme reached its conclusion in March 22, following a comprehensive four-year programme of collaboration between Wales and the Midlands and wider collaboration across the UK through the ATTC network.
The programme has reported its achievements and legacy plans and events have been held to showcase and celebrate this initiative.

Two celebratory meeting events were held in March:

- *ATMP Clinical Adoption Forum – The UK's Role in the Global ATMP Ecosystem,* London (24th March), hosted by Cell and Gene Catapult.
- *Consortium Executive Meeting* (25th March), hosted by Midlands and Wales Advanced Therapy Treatment Centre.

This paper provides an overview of the achievements of the programme and the next steps for the sector in Wales.

2. BACKGROUND

In September 2017, Innovate UK, the UK innovation agency, announced a two phase £30m grant competition to establish three ATTCs. A consortium, the Midlands & Wales Advanced Therapy Treatment Centre (MW-ATTC) – jointly led by the Welsh Blood Service (on behalf of NHS Wales) and the NIHR Birmingham Biomedical Research Centre, was successful in securing one of the three awards and £7.3m in grant funding (£1.5m to NHS Wales, 2018-2021). The additional partners in the consortium all have specific expertise in different aspects of the overall production and delivery of advanced therapies. In April 2021 Innovate UK awarded a further £2m (£0.5m approx.to NHS Wales, 2021-2022) for a twelve-month extension of the programme in recognition of the impact of the pandemic.

The overarching objectives of all the ATTCs were to: develop and disseminate standard protocols, systems, processes and best practice across the NHS, and associated commercial supply chain; to facilitate and expedite the broad deployment, adoption and enable timely, equitable patient access to these advanced therapies.

The MW-ATTC work programme was formally initiated in March 2018 and its focus areas are to:

- Set up a network of hospitals with medical staff trained to receive and administer ATMP's

- Build seamless supply chains that ensure that 'living medicines' remain healthy and effective as they are moved from the production laboratory to the bedside.
- Specify and prototype IT systems to manage the end-to-end process.
- Validate the infrastructure using real ATMP's.
- Utilize the new infrastructure and processes to accelerate the testing of ATMP's in clinical trials.
- To build upon recognized international expertise to investigate and appraise the current commissioning processes / models to ascertain whether the costs of ATMP's is justified by clinical effectiveness with the aim to inform the reimbursement / commissioning process of the future.

The consortium consisted of 16 organisations representing the NHS, academia and industry. The overall programme consisted of eight work packages, (Fig.1, see below) containing a total of 341 deliverables in total. All deliverables will be completed upon formal closure of project, (31st March 2022)

- WP0 – Programme Management & Public and Patient Involvement and Engagement
- WP1 – Clinic Delivery (Organisational Readiness & Education)
- WP2a – ATMP Logistics and Orchestration (Electronic solution for the management of cell handling)
- WP2b – Logistics (End-to-end cryochain solution using hardware and software systems & Development of viable logistics platforms)
- WP3 – The manufacture of Allogeneic & Autologous ATMPs for clinical testing
- WP4 – Validation and Trials Acceleration Programme (TAP-CT)
- WP5 – Economic Evaluation and Market Access
- WP6 – Informatics (Registry and Order-Comms components)

Fig.1. MW-ATTC Work Packages.

The programme has delivered a wealth of knowledge and resources including a toolkit to enable organisations to establish the clinical, operational and regulatory requirements to deliver ATMPs which is already being used across the world.

A full summary of the achievements of the initiative is provided in Appendix 1.

Appendix 1. MW-ATTC Brochure March 2022

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Funding and ongoing activity

The MWATTC programme sat alongside the Wales specific Advanced Therapies Wales Programme (ATW) which continues to receive and annually awarded fund from Welsh Government to enable delivery of the Statement of Intent for Advanced Therapies from which the MWACCT initiative developed.

Midland and Wales Advanced Therapy Treatment Centre's (MW-ATTC) funding expired on the 31st March 2022. Innovate UK have stated that cell and gene therapies remains as one of their priority themes but to date have not committed further funding to support the Advanced Therapy Treatment Centre's. At present Cell and Gene Therapy Catapult is to continue and will host materials produced from the three ATTC's.

In the absence of securing funding to continue there has been discussion between all three ATTC's to secure a 'keep the lights on' approach for the core programme / project teams and to enable further collaborative opportunities to be explored, pending further funding. The MWATTC and wider ATTC initiative has created a network of industry, academic and NHS colleagues who have developed and shared knowledge and skills which we need to maintain. In Wales the ongoing link to the MWATTC work will be via the ATW programme team. The aim is to continue the consortium with a 'terms of agreement' until such time Innovate UK announce funding intentions. The Advanced Therapies Wales programme will provide the link to ensuring a working relationship with MW-ATTC.

The Cell and Gene Therapy Catapult in conjunction with the three ATTC's have developed a number of bridging projects aimed to run during this interim period. These will be partially funded by industry and the Catapult is seeking the remaining funding before starting the projects. ATW will continue to engage with this work and facilitate wider links between ATTC colleagues and NHS Wales. These projects include:

- CAR-T Patient Referrals Pathway Gap Analysis
- Barriers to Ambulatory or Outpatient Delivery of ATMP Treatments
- Apheresis Service Horizon Scanning

3.1 Financial Implications

There are no ongoing financial implications for the MWATTC programme. All future activity will be resourced via ATW or new funding sources.

4. 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.

RECOMMENDATION

The Executive Management Board are asked to **NOTE** the final report on MW-ATTC and the ongoing engagement with the ATTC network via ATW.

Advanced Therapy Treatment Centres

Midlands-Wales Advanced Therapy Treatment Centre

Accelerating cell and gene therapy adoption

Funded by

UK Research and Innovation

Coordinated by

CATAPULT Cell and Gene Therapy

Our Collaborators

University Hospitals Birmingham NHS Foundation Trust

University of Birmingham

GIG CYMRU NHS WALES – Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

NHS Blood and Transplant

NHS Cambridge University Hospitals NHS Foundation Trust

NHS Nottingham University Hospitals NHS Foundation Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

NHS University Hospitals of Leicester NHS Foundation Trust

NHS Birmingham Women's and Children's NHS Foundation Trust

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4 FOUR PLUS

InstilBio

ixaka

ThermoFisher SCIENTIFIC

Miltenyi Biotec

TrakCel

OrbsenTherapeutics – Redefining Cell Therapy

World Courier – AmerisourceBergen

Aston University BIRMINGHAM UK

Prifysgol Bangor University

University of Oxford

Swansea University Prifysgol Abertawe

Contents

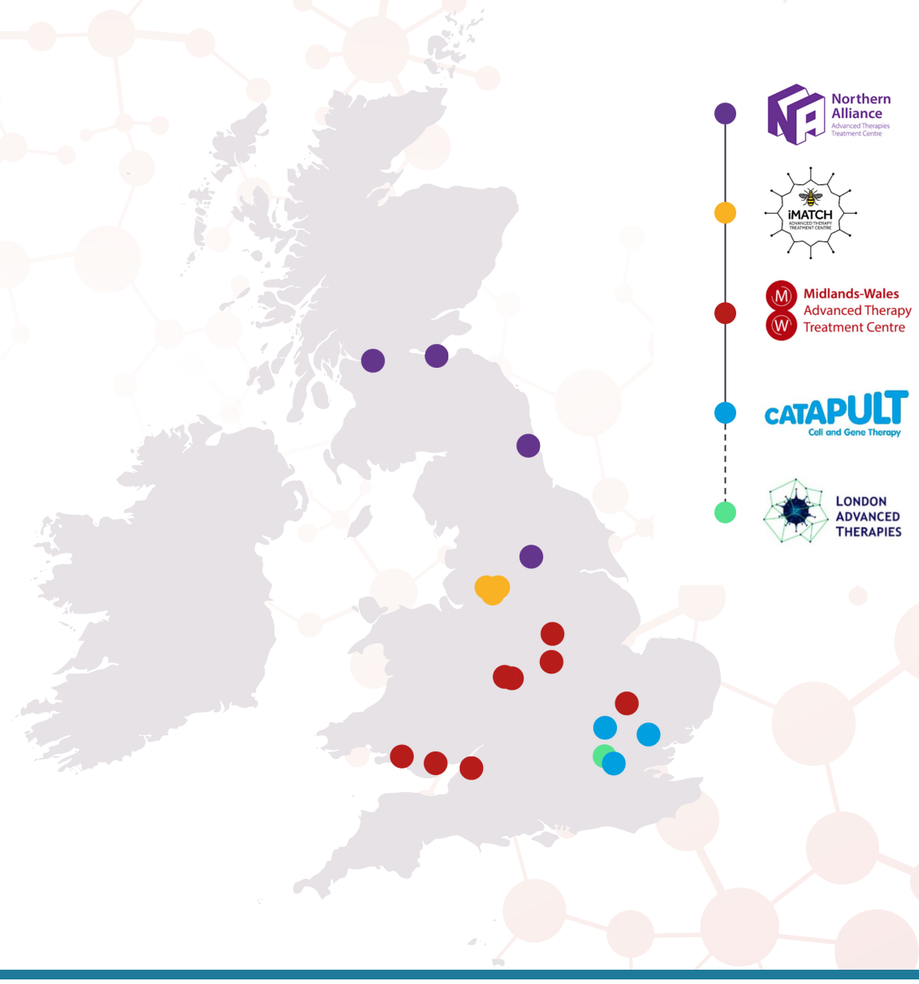
The ATTC Network

In the last decade multiple new cell and gene therapies have been developed to treat cancers and a range of inherited diseases. These advanced therapies are different from existing treatments in terms of their ability to potentially offer curative approaches and also their disruptive impact on ways of working in the NHS.

The Advanced Therapy Treatment Centres (ATTC) are a world-first, UK system operating within the NHS framework and coordinated by the Cell and Gene Therapy Catapult (CGT Catapult) to address the unique and complex challenges of bringing pioneering advanced therapy medicinal products (ATMPs) to patients. The 3 UK centres are:

- Midlands-Wales Advanced Therapy Treatment Centre (MW-ATTC)
- Northern Alliance Advanced Therapies Treatment Centre (NA-ATTC)
- Innovate Manchester Advanced Therapy Centre Hub (iMATCH)

The network was supported by the Industrial Challenge Strategy Fund delivered by UK Research and Innovation with the aim to develop first-of-a-kind technologies for the manufacture of innovative medicines across areas including blindness, cancer, heart failure, liver disease, neurological conditions and rare paediatric diseases. The ATTCs are working together with industry partners, academic partners and the wider public sector to deliver the necessary processes, skilled staff and infrastructure at a scale that will be needed as more treatments move from clinical trials to marketed products.



Northern Alliance Advanced Therapies Treatment Centre

iMATCH Innovate Manchester Advanced Therapy Treatment Centre

Midlands-Wales Advanced Therapy Treatment Centre

CATAPULT Cell and Gene Therapy

LONDON ADVANCED THERAPIES

Midlands and Wales Advanced Therapy Treatment Centre

The Midlands and Wales Advanced Therapy Treatment Centre (MW-ATTC) is a regional network which initially comprised of 13 partners. We have grown in the last four years to 20 partners and our clinical reach now extends to Cambridge, Bristol, Leicester and Oxford. Industry, healthcare and university partners have worked alongside each other to create solutions to challenges identified in delivering ATMPs to patients across eight work packages.

We have created robust processes to maintain chain of identity and custody from procurement to administration for our exemplar ATMPs, including comprehensive monitoring and data management. We have tested and integrated market-leading solutions for ATMP transport and tracking using state-of-the-art IT systems. The clinical teams have established an expert network across a number of hospitals with the requisite skill needed to receive and administer ATMPs. We have also worked closely with logistics and manufacturing partners to create more efficient pathways and increase access to clinical trials.

The aim of the MW-ATTC is to enable UK advanced therapy companies to reach the clinical market, whilst simultaneously building clinical capacity and capability regionally to deliver these breakthrough therapies to patients

We welcome approaches from advanced therapy companies, logistics partners and NHS Boards and Trusts to join our network .

Leadership

Professor Philip Newsome

Director

Phil Newsome is Professor of Hepatology, Director of the Centre for Liver and Gastrointestinal Research at the University of Birmingham and, Consultant Hepatologist at the Queen Elizabeth Hospital in Birmingham, United Kingdom where he is the Deputy Director for the Birmingham NIHR Biomedical Research Centre. He also recently completed his term as Secretary General (President) at the European Association for the Study of the Liver.

He has extensive experience of delivering and managing large programmes, delivering cell therapy studies across the UK, internationally and working alongside industry. He runs a large laboratory group focussing on the role of cell therapy in liver injury and has established three cutting edge clinical trials where he is the Chief Investigator. One of these, REALISTIC was the largest clinical trial of haematopoietic stem cell therapy in patients with liver cirrhosis in Europe/US. The others include the MERLIN consortium, which is a clinical trial of mesenchymal stromal cells in patients with primary sclerosing cholangitis (PSC) and the POLARISE basket trial in patients with PSC, Rheumatoid Arthritis, Crohn's disease and Lupus Nephritis.

Professor Newsome's research portfolio has led to high impact publications throughout, including both original articles (NEJM, PNAS, Gastroenterology, Hepatology, Journal of Hepatology, Gut, American Journal of Transplantation, Annals of Internal Medicine, Lancet, Nature and Nature Comms) and review articles (FASEB, Gastroenterology, Journal of Hepatology).

Dr Mark Briggs

Co-Director

Mark Briggs is the Assistant Director for Innovation for Cardiff and Vale University Health Board and the Precision Medicine Ambassador for the Life Sciences Hub Wales. Prior to these roles he was Programme Lead for Advanced Therapies Wales and both Head of Cell and Gene Therapy for the Welsh Blood Service and Head of Strategy for Research, Development and Innovation for the Velindre Cancer Centre within the Velindre University NHS Trust.

Prior to moving to the public sector Mark spent more than 20 years within R&D in the commercial Life Sciences industry in a series of senior roles leading the development and application of enabling and disruptive technologies primarily for drug discovery, development, safety testing. In his latter corporate years, he focussed upon the industrialisation of advanced therapies with a view to enabling safe and robust, turn-key production of both genetically and non-genetically modified cellular therapies. During this time, he was co-author on numerous peer-reviewed publications and co-inventor of several granted international patents.

Supporting Clinical Adoption

Advanced Therapies NHS Readiness Toolkit

The NHS readiness toolkit is a pan-ATTC output which provides resources for healthcare organisations that are working towards the delivery of advanced therapies for patients.

The Toolkit is intended for senior hospital management, operational managers, clinicians, pharmacists, nurses, laboratory teams and others involved in the delivery of advanced therapies.

Governance	Strategy, business and financial planning	Quality risk management	Operational delivery	Clinical practice	Education and training	Long term follow up
21	10	13	44	40	51	1

Examples of published documents

Case Study: NHS Readiness

The challenge

There has been an exceptional growth in Advanced Therapy Medicinal Products (ATMPs) development in recent years which is creating an unprecedented challenge to the NHS. The UK healthcare system is well-equipped to deliver conventional therapeutic products, however these innovative cell and gene therapies require the development of new infrastructure, systems, processes, and skilled staff in order to treat patients safely and at scale as these ATMPs move from clinical trial to marketed products.

The solution

In response to this challenge, three Advanced Therapy Treatment Centres (Midland Wales [MW-ATTC], Northern Alliance [NA-ATTC] and iMATCH) were established in 2018. These centres act as a network, supported by the Cell and Gene Therapy Catapult. They have developed a range of key, free-to-access, materials aimed to inform, educate and expand NHS expertise and delivery of Advanced Therapies. MW-ATTC focussed on the creation and delivery of a range of information and resources to provide and support NHS organisations with a variety of tools to enable the successful delivery of ATMPs. These wide-ranging materials include;

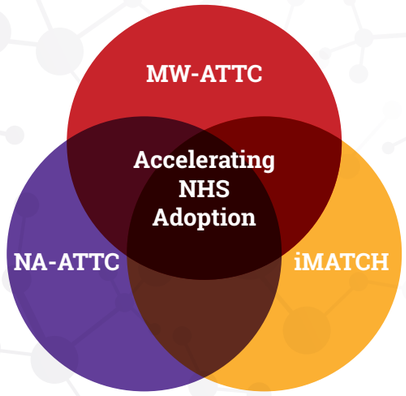
- Educational material, i.e. Introduction to Advanced Therapies, logistic / carrier training and competency assessments etc.
- Pharmacy governance, template protocols and checklists etc.
- Organisational guidance generic Advanced Therapy pathways, CRF matrices, workforce identification hierarchy etc.

NA-ATTC produced a number of guidance documents and toolkits which clinical sites can utilise to accelerate the adoption of ATMPs, both through clinical trials and licensed medicines, examples include:

- An Institutional Readiness toolkit and questionnaire which allows NHS clinical sites to assess their own Institutional Readiness levels for the four classes of AT medicines – tissue engineered, cell-based gene, somatic cell and virus-based gene products.
- A clinical trials toolkit which includes costing guidelines.
- A suite of guidance documents and SOPs for clinical delivery and management of CAR T-Cell Therapies.
- Guidance for developing a hospital business case for ATMP service provision.
- Pharmacy governance and preparation facilities requirements for gene therapies.

iMATCH's key Institutional Readiness activities focus across education, governance and safe patient management to increase patient access to ATMPs. Materials generated include:

- Education programme to up-skill the workforce and aid delivery.
- Presentations were developed as aids e.g. JACIE readiness for immune-effector cells and ATMP Pharmacy training.
- Governance structures and terms of reference across various committees e.g. ATMP Board.
- Oncology adoptive T-cell therapy mapping – concept and complexities of the patient pathway.
- Checklists for handling ATMPs e.g. Thawing Checklist.



The results

The NHS Readiness Toolkit, launched in April 2021, was developed to provide easy access to the portfolio of resources created by the ATTCs. These resources span 8 categories, including governance, operational delivery and clinical practice, and allow hospitals to evaluate their readiness to deliver ATMP, and demonstrate and embed best practice by preparing UK healthcare organisations to develop local structures, systems, pathways, procedures, processes and workflows.

Advanced Therapy Treatment Centres

Northern Alliance Advanced Therapies Treatment Centre

iMATCH Advanced Therapy Treatment Centre

Midlands-Wales Advanced Therapy Treatment Centre

Examples of categories within the NHS Readiness Toolkit

Making further impact

The NHS Readiness Toolkit was visited by over 10,000 users within the first nine months of its launch, demonstrating a clear need for these resources. Feedback from users has highlighted the impact which the Toolkit is already making, and as the ATTC programme matures and further outputs are shared, the Toolkit's reach is anticipated to extend.

"I find the NHS Readiness Toolkit provides me with a go-to repository of guidance to support the service implementing advanced therapies into the clinical setting. Some of the resources I have found most helpful are the training, education components as well as the clinical practice section which holds useful information such as the thawing SOP and checklist."

Debbie Worthing, Lead Research Nurse Advanced Therapies Programme

"The Advanced Therapies NHS Readiness Toolkit has been a vital resource for me in coordinating ATiMP cancer trials. In particular, the Clinical Practice guidance and the tools in its Education sections were the best I have found for teaching both research-familiar and research-naïve NHS staff about the differences and complexities of ATiMP trial work, which has benefitted us when planning and managing our early-phase ATiMP cancer trials."

Sam Moody, Clinical Trial Coordinator in Newcastle

As more hospitals prepare to deliver advanced therapies, the resulting impact will be clear for the greater number of patients who are able to access these life changing medicines faster than ever before.

Access the NHS Readiness Toolkit here

Advanced Therapy Treatment Centres

Northern Alliance Advanced Therapies Treatment Centre

iMATCH Advanced Therapy Treatment Centre

Midlands-Wales Advanced Therapy Treatment Centre

Education

Our ATTC has added significantly to training and education and we contribute to each of the elements below. We have also worked alongside our pan-UK training community to create new resources.

Training videos

- Thawing and inspecting frozen cell products
- Management of Cytokine Release Syndrome
- Transporting of Advanced Therapies

Expert led webinars

- 34 pan-ATTC recorded webinars
- 15 of which led by MW-ATTC

Competency assessments

- Procurement, infusion, Handling, Medical Equipment and spillage SOPs
- Patient pathway flowsheets
- Training Matrix

E-Learning Modules

- Introduction to ATMPs
- Low temperature transport
- CAR-T cell therapy
- In Vivo gene therapy
- ATMP logistics in hospitals
- Immune effector cell therapy

Exemplar protocols, policies & risk assessments

- Storage, transfer, receipt and checklists
- Study intensity protocol
- GTMP approval
- GMO risk assessment

Resources to support face-to-face training

- Procurement, infusion, handling, medical equipment and spillage SOPs
- Patient pathway flowsheets
- Training Matrix

Formal courses

Case Study: Education and Training

The challenge

Advanced therapy medicinal products (ATMPs) have the potential to address significant and growing unmet healthcare needs. These treatments offer exciting therapeutic and potentially curative options for diseases which cannot be addressed adequately by existing pharmaceuticals. The UK is at the leading edge of this disruptive field and there is an opportunity to build a large-scale industry delivering health and wealth to the country. Currently in the UK, there is no coordinated education and training programme on advanced therapies available to existing NHS staff, despite the rapid pace with which new therapies are becoming available. ATMPs are complex treatments, requiring innovative ways of working, and new knowledge and skills, for the many staff groups involved in their clinical delivery. These therapies also present urgent learning needs for the wider healthcare community and for teams responsible for clinical education and training.

The solution

Contributions from a network of subject matter experts have guided the development of a structured syllabus intended to provide healthcare professionals with the required underpinning knowledge and awareness of ATMPs to supplement further product-specific and practical training in the workplace.

MW-ATTC advanced therapy syllabus for healthcare professionals

Core educational material

Introduction to advanced therapies

Slide deck training aid:
Introducing basic concepts
ATMP classifications
Autologous vs allogeneic
Brief examples
Regulation overview
Key challenges

e-Learning package:
Introduction to advanced therapies*

Aston University
online slides

Aston University
workshop

Advanced therapy receipt & handling

Slide deck training aid:
Checks on receipt
Dispensing checks
Possible problems
Spills & disposal
Lines of communication
Dosing considerations

Slide deck training aid:
Inspecting cell therapies
Thawing frozen cell therapies

Exemplar SOP on thawing
frozen cell therapies

NHSBT e-Learning:
Low temp transport vessels

Exemplar risk assessments
(dry shippers & dry ice)

Video: transporting advanced
therapies

Supplementary educational material

Collection of advanced therapy starting material

Slide deck training aid:
HTA, MHRA, JACIE
Apheresis
BM harvest
Cord blood collection
Tumour excision for TILs
Venesection

Structured learning visit to
apheresis unit
with short workbook

NHSBT e-Learning:
apheresis and
anti-coagulation

Introduction to gene therapies

e-Learning package:
Intro to *in vivo* gene therapy*

Slide deck ± videos or
animations: gene therapy
governance
Risk assessments
GMSC
HSE
Ordering & prescription
Range of SOPs
Nurse check lists
Chain of custody

Video:
Gene therapy preparation
Documentation and checks
Administration
Cleaning and disposal

Introduction to immune effector cell therapies

e-Learning package:
Intro to Immune effector
cell therapy*

e-Learning package:
Focus on
CAR T cell therapy*

NHSBT Video:
Patient experience of receiving
CAR T cell therapy

Midlands-Wales
Advanced Therapy
Treatment Centre

* e-Learning developed collaboratively as part of pan-UK training working group
All offline training to be locally adapted, delivered and tracked as required

The results

Training packages produced by NHSBT are two of the most frequently downloaded resources on the ATTC network website and have been implemented at several face-to-face training sessions, generating positive feedback.

- An animated video on transporting advanced therapies was produced by NHSBT in collaboration with World Courier. The video is primarily aimed at logistics personnel but is accessible for anyone requiring a brief introduction to the advanced therapy supply chain. This video has also been widely used across the ATTC network.
- Findings from a training needs analysis survey were summarised in a report co-written by NHSBT and the Cell and Gene Therapy Catapult.
- An introductory training workshop was successfully piloted by Aston University in conjunction with MW-ATTC and future courses and training packages are planned.
- A short video has been produced to communicate a patient's experience of receiving CAR-T cell therapy.
- Training is being created for research nurses to explain processes involved in collecting starting material for the manufacture of advanced therapies. This will be supplemented by a workbook to provide structured learning objectives for visiting an apheresis unit.
- An e-learning package and exemplar risk assessments are being developed on the safe use of dry shippers and dry ice.
- A competency assessment framework is being developed to record and measure successful staff training.

Making further impact

The Cell and Gene Therapy Catapult are coordinating the development of education and training across the ATTCs and London Advanced Therapies network. A series of e-learning modules are being developed by a team working collaboratively across the network, with an in-built programme of review and testing by clinical experts and end users to ensure quality assurance of training content. The outputs of this joint approach will be made widely accessible to the UK health and social care workforce via Health Education England's e-Learning for Healthcare hub. This learning platform is an authoritative and trusted source, supporting our standardised, national approach that will equip NHS staff with theoretical knowledge and awareness to complement their practical training in the workplace.

ATTC Advanced Therapy Treatment Centres

NHS Blood and Transplant

Aston University Birmingham UK

Midlands-Wales Advanced Therapy Treatment Centre

Patient and Public Involvement & Engagement

3 Patient experience videos

Nitya's Story - What is it like to receive CAR T cell therapy?
22nd July 2020 | Midlands - Wales News

The first video was produced by NHSBT in collaboration with University Hospitals Bristol and Western NHS Foundation Trust.

Nitya, a University student from Gloucestershire, was the first patient to undergo CAR T cell therapy at the Trust in February 2019.

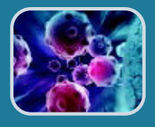
The next two videos are of Anne and Sophie, both patients who have also received CAR T therapy at University Hospitals Birmingham NHS Foundation Trust explain how they met by chance outside the Pharmacy department and struck up a friendship. They go on to describe their experience of the treatment.

ADVANCED THERAPIES 2021

An interactive series introducing cell and gene therapies.

Introducing cell and gene therapies

Ask the experts: Liver disease and rheumatoid arthritis



Ask the experts: Cancer

Pharmacy, logistics and a look to the future

3 Publications

1 Patient and Public group

A scoping review of patient and public perspectives on cell and gene therapies

Patient and public perspectives on cell and gene therapies: a systematic review

Production of a patient toolkit for manufacturers and Sponsors

Case Study: PPIE

The challenge

Over the last decade, new advanced therapy medicinal products (ATMPs) have been developed to treat various cancers, inherited diseases and chronic conditions. Although they offer ground-breaking new opportunities for the treatment of disease and injury, the uptake of these therapies requires appropriate patient and public engagement and buy-in. There is therefore a need to offer patients and their families educational resources which provide accurate, relevant and valued information about ATMPs in order to increase their knowledge and understanding and empower them in making decisions about these therapies, which may also potentially improve patient recruitment for ATMP trials.

The solution

In order to gain an initial understanding of patient perspectives of ATMPs, a comprehensive systematic review of published literature on the subject was recently conducted within the MW-ATTC (Aiyegbusi et al 2020, Nature Communications). The high-impact review included 35 publications and summarised findings on patient concerns, expectations and information needs relating to ATMPs.

The results

The systematic review revealed a number of misconceptions about ATMPs among patients and the general public. The review also highlighted a lack of accurate information and clarity about the potential benefits and risks of these novel therapies. These issues have led to over-optimism in some patients and a lower level of acceptance in others. Acceptance of cell and gene therapies varied among patients but generally increased after the provision of information.

Making further impact

Utilising the results of the systematic review, particularly the gaps in educational resources which were highlighted, the MW-ATTC are developing a series of informational webinars aimed at patients and the public which will be delivered virtually in the summer of 2021. Additionally, patient and public partners in MW-ATTC focus groups will contribute to the shaping and creation of new materials within the centre which will address topics identified in the review.

View all of our resources for patients and the public here

ATTC Advanced Therapy Treatment Centres

Midlands-Wales Advanced Therapy Treatment Centre

Logistics and Orchestration

Identifying the potential issues & developing solutions for clinical sites delivering ATMPs

ATTC Logistics Solutions

Collection of Starting Material for Autologous Product

- MW-ATTC Informatics Project Electronic solution prototype
- Sample Project: Standardization of apheresis material and surgical tissue collection

Collection of Autologous Material by Courier

- Checklist: Transfer of starting material
- Training Video: Transporting ATMPs
- Experienced / Licensed Couriers – World Courier

Transport to Manufacturer

- Guidance: Regulatory requirements for export of ATMP starting materials
- Bespoke 'Track & Trace' software platform – TrakCel

Processing & QP release

- Audited trial runs across 4 hospital sites informed process and policy
- Nitrogen free cryo shipper (VIA Capsule™) – Cytiva

Transport to Treatment Centre / Long Term Storage Facility

- Long term storage at licensed Bio Banking Facility – Thermo Fisher
- Secondary labelling, packaging also offered

Receipt of ATMP Product at Treatment Centre

- Checklists: Receipt and storage of Fresh / Cryopreserved Allogeneic & Autologous ATMPs
- Risk assessment example – Shipments received in electric shipper

Storage at Treatment Centre

- Competency Assessment / Guidance: Use of Dry Ice / Shippers
- Assessment Form: Storage of ATMPs in non pharmacy department

Release by Pharmacy

- SOP/Checklist: Transfer of shippers to clinical areas & return of shippers

Patient / Treatment

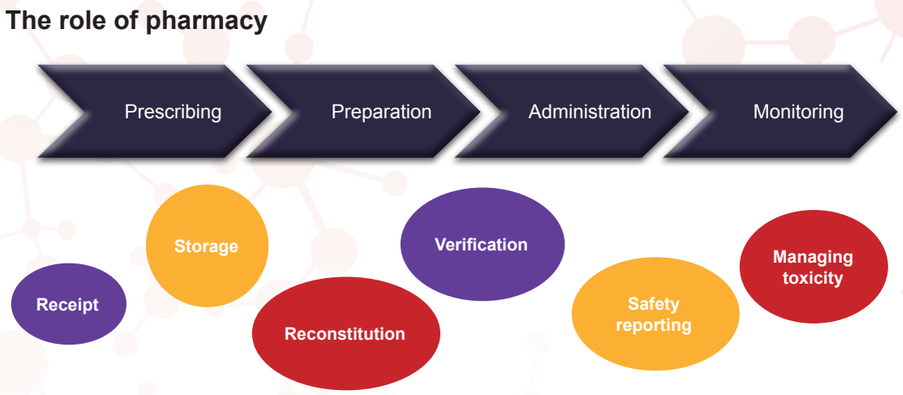
- Risk Assessment: for activities involving GTMPs or GTIMPs / preparation and administration of ATMPs
- Training: Visual guide to Preparation, Administration & Disposal of GMOs in clinical settings / Visual inspection of ATMPs
- Competency Assessment: Thawing of cryopreserved ATMPs products
- SOP: Management of GMO spillage / Administration of in-vivo gene therapies

Case Study: Pharmacy Standardisation

The challenge

Advanced therapy medicinal products (ATMPs) have substantially different pathways through patient care compared to conventional treatments. These products may be manufactured for specific patients following harvest of a patient's blood or bone marrow and may be only suitable for that particular patient (autologous). Other ATMPs are made on a larger scale, allowing many patients to be treated from the same manufacturing batch (allogeneic).

All ATMPs have specific storage, handling and dispensing instructions that must be followed to ensure that the quality and safety of products are maintained. Pharmacists are responsible for ensuring that the ordering, storage, reconstitution and dispensing of ATMPs are in line with their product specifications, patient clinical needs and protocols when the products are offered as part of a clinical trial.

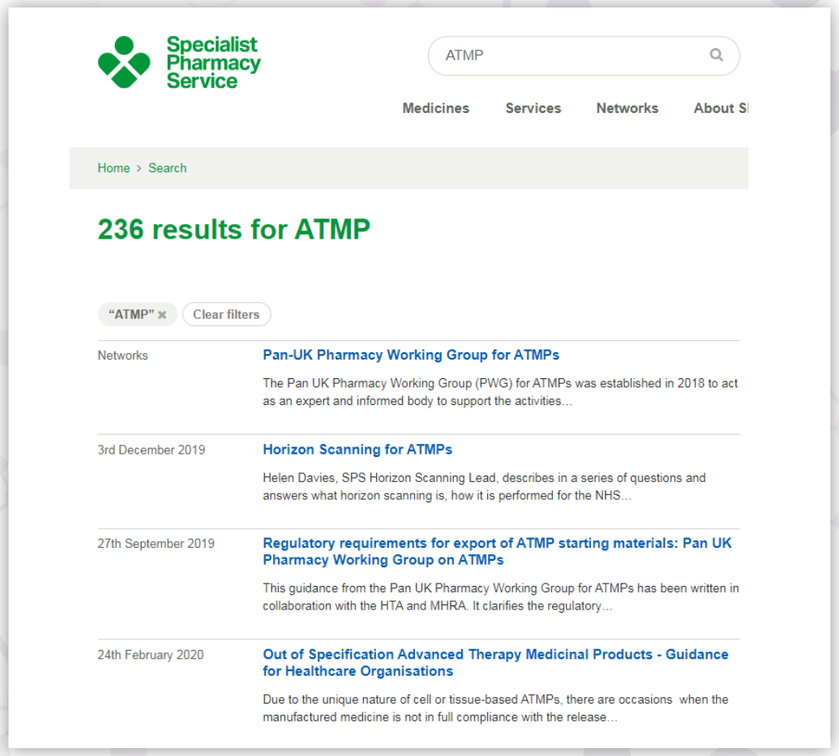


The solution

The pan-UK Pharmacy Working Group (PWG) is acting as an expert and informed body to support the activities of the three ATTCs and, indeed, hospitals around the UK in the administration of ATMPs. The group consists of pharmacists from across the UK that specialise in the governance, clinical trials, prescribing, administration and monitoring of ATMPs and is an excellent example of collaboration across the NHS. The aims of the group are to promote good practice, identify and resolve pharmacy issues to maximise the effectiveness and development of services for hospitals to administer advanced therapies.

The results

The group has developed guidance and checklist documents in the implementation of ATMPs to provide consistency in governance, clinical and operational aspects for pharmacies across the country. The PWG is now formally a Specialised Pharmacy Service Network and is becoming an important partner to the NHS in the administration and commissioning of ATMPs and will continue to develop best practice and guidance for this class of medication[1].



Specialist Pharmacy Service

Making further impact

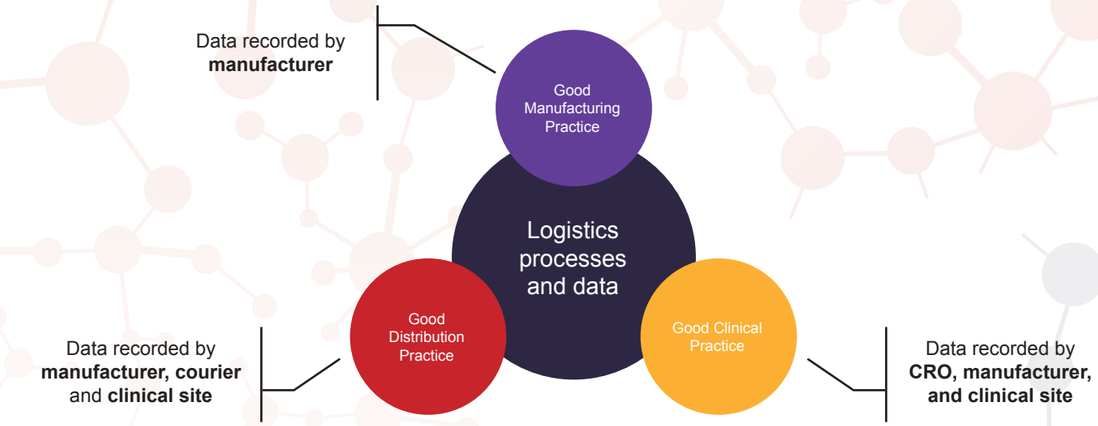
As new hospitals begin to use ATMPs in the clinic, there are procedures and checklists are available to support clinical staff. Commercial ATMP developers also benefit due to the more consistent approach at different hospitals, making set up at different sites a smoother process.

Advanced Therapy Treatment Centres · iMATCH Advanced Therapy Treatment Centre · Northern Alliance Advanced Therapies Treatment Centre · Midlands-Wales Advanced Therapy Treatment Centre · Specialist Pharmacy Service

Case Study: Simplifying Logistics

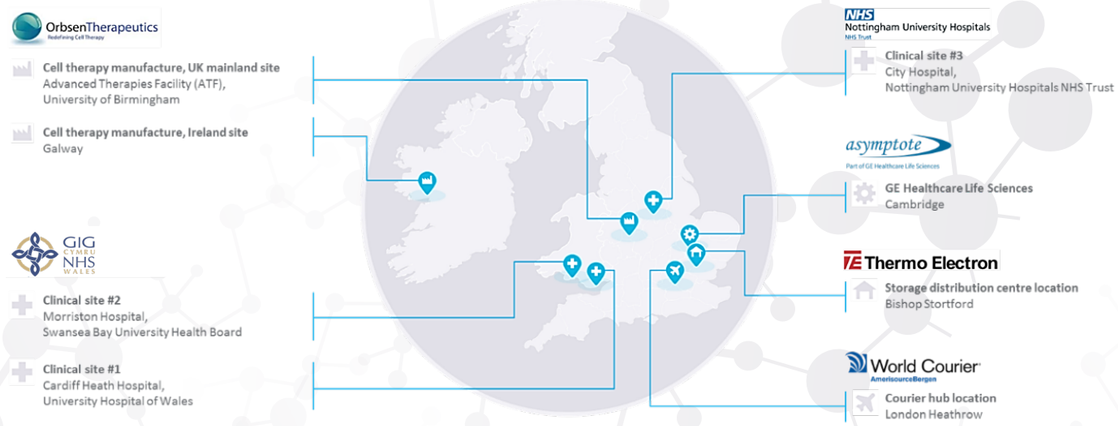
The challenge

Cell and gene therapies are expensive and complex treatments to manufacture. These treatments need to be accurately monitored to maintain the viability of the product once it reaches the patient. The issue with the data for the logistics of cell and gene therapies is that data collection is recorded by multiple parties; the manufacturer, courier, CRO and clinical site.



The solution

As a part of the Midlands-Wales Advanced Therapy Treatment Centre (MW-ATTC) project, an integrated cell therapy logistics network is being developed and tested to ensure a robust process is in place for the delivery of ATMPs into the clinical setting.



The results

Throughout the process, Cytiva's Chronicle™ product was used to capture data generated at different points, standardising the process and managing documentation

- Chronicle™ eSOP tool captures delivery process and reads barcodes
- Dashboard monitors shipper location and condition
- Integrates with World Courier system to record documentation and events
- Managing chain of custody and identity

Making further impact

Chronicle™ is being further tested and developed as a part of the MW-ATTC programme. The system is being built to unite manufacturing and logistics data, accurately recording and tracking products from manufacture to thawing at clinical sites to speed up and simplify the running of these complex trials.

ATTC Advanced Therapy Treatment Centres

Midlands-Wales Advanced Therapy Treatment Centre

asymptote Part of GE Healthcare Life Sciences

World Courier AmerisourceBergen

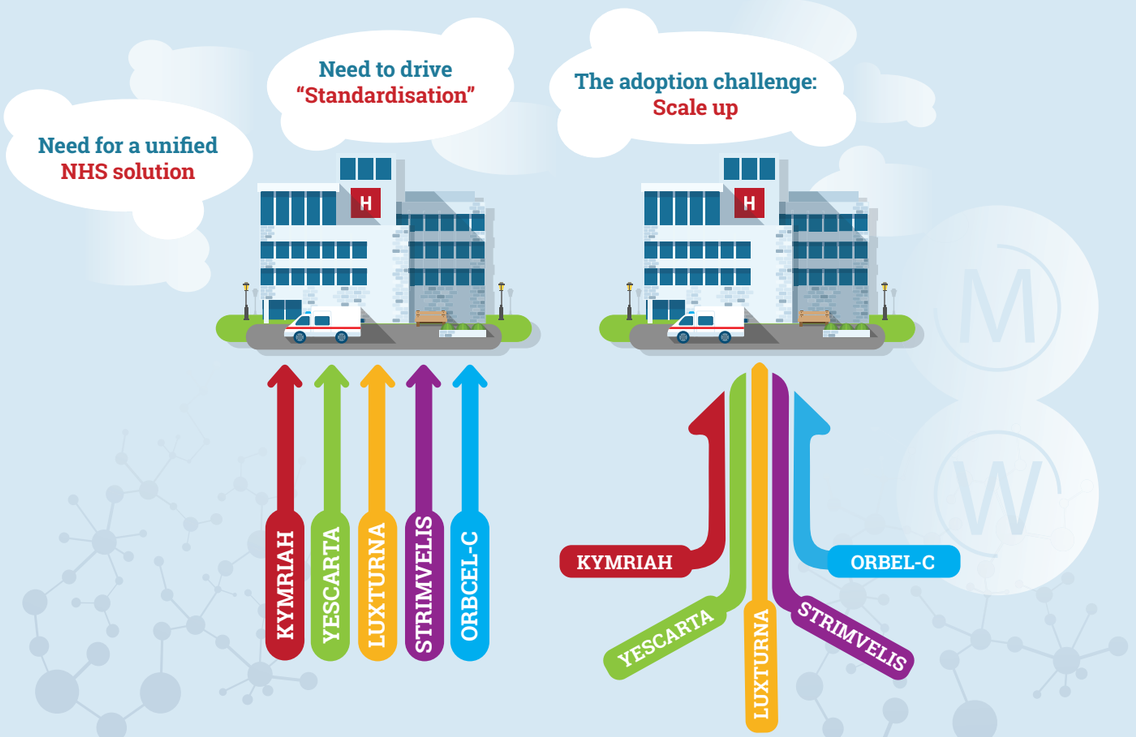
ThermoFisher SCIENTIFIC

OrbsenTherapeutics

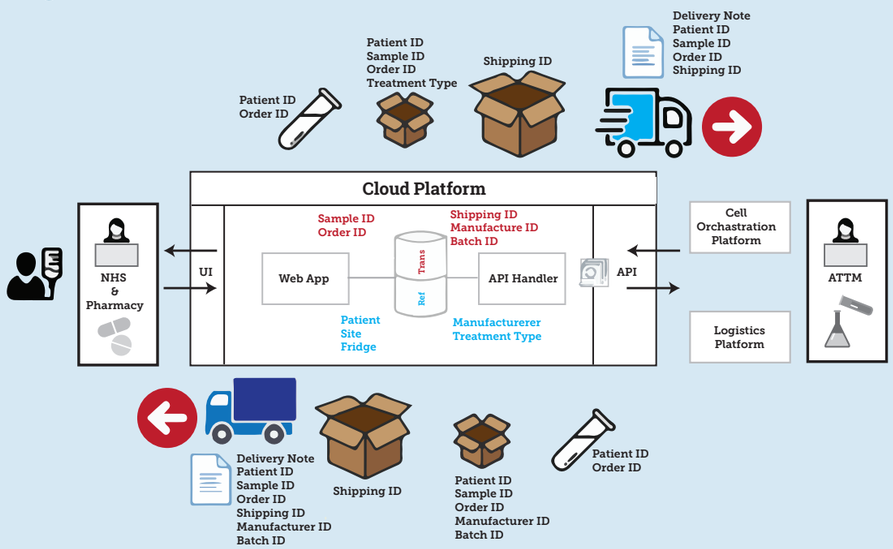
Electronic Solution for Hospitals

Advanced Therapy Medicinal Products are moving at pace from clinical trials into routine clinical care.

Due to the logistical complexity, currently each therapy provider is setting up an individual track and trace solution resulting in a multiplicity of ATMPs systems and extra burden for the NHS.



ATTC System Interactions

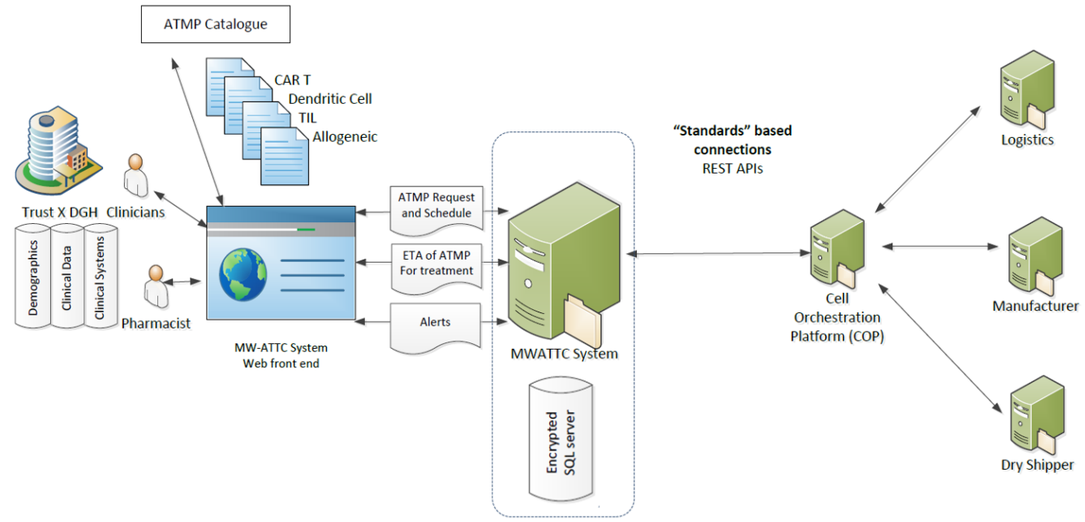


This was achieved by UHB Informatics in collaboration with our industry partners providing manufacturing insights, building upon existing MW-ATTC Cell Orchestration Platform (COP) infrastructure to further increase the robustness of the scheduling and maximising the utilisation of expensive manufacturing resources provided by the University of Birmingham.

For the NHS a web based prototype system was built on a Cloud based platform, to standardise the Ordering and Scheduling of ATMP Treatments for the NHS, in collaboration with industry partners and manufacturers, to deliver trackable 'needle-to-needle' ATMP products for ATMP Patients. The prototype allows at least one ATMP to be ordered and scheduled via a catalogue from an NHS Trust that delivers ATMP treatments. This system should be able to interface with one or more Cell Orchestration Platforms and one or more Advanced Therapy manufacturers.

Our design approach was based on a standard Ordering system as shown below.

The system



The Benefits

- Removal of administrative burden that makes current processes difficult and time consuming
- To allow the NHS to be aware of where their treatment is in manufacturing and delivery processes
- Helps NHS with treatment scheduling & a single UI for NHS Staff to familiarise themselves with
- Moves NHS towards mainstream ordering of ATMPs
- Provides data points to assist payer mechanism
- Provides "Standards" based APIs for COP and Advanced Therapy services suppliers integration
- All the above will speed-up the adoption and reduce implementation and operational costs

Watch our webinar to find out more

Trials Acceleration Programme in Cellular Therapy (TAP-CT)

Advanced Therapy Medicinal Products (ATMPs) are novel and potentially life-changing therapies for a range of diseases including rare conditions with no current effective treatment. Accelerated delivery of pivotal clinical trial is essential if patient benefit is to be maximised. However, set up processes are still slow and patient recruitment to complex therapies remains challenging. The ATTC network has almost doubled the number of ATMP trials and now runs 6% of all global ATMP trials.

However, to meet the ambitious target of >10,000 patients accessing cell therapies by 2029, we must develop innovative ways of accelerating patients onto trials to receive pioneering treatments.

Modelled on existing trials acceleration programmes IMPACT and Cure Leukaemia TAP, we have set up a network of nine sites staffed with dedicated research nurses with expertise in cellular therapy trials and ATMPs) in order to fast-track opening of critical trials and widen patient access to these life-changing treatments.

Who are we?

The network is coordinated by the University of Birmingham, and each site has funded resource to support ATMP trial set up and opening. We work with both commercial and academic sponsors to facilitate accelerated set up and opening of exciting cell and gene therapy trials across a network of clinical sites spanning a large geographical area.

What we offer:

- A large and diverse patient population across the Midlands, South Wales, Bristol, Oxford and Cambridge of more than 20 million, which will help improve meeting recruitment targets for complex trials, in particular those in rare diseases
- Dedicated nursing or clinical trials coordination resource to navigate the set-up process and to support recruitment and training of research nurses
- Resource and information to conduct rapid feasibility for Sponsors
- Access to key opinion leaders across the network in a number of clinical areas, including:

Cardiology; Covid-19; Diabetes; Gastrointestinal Disease; Haematology and Haemato-oncology; Immunology; Liver Disease; Metabolic and Endocrine Disease; Neurological Disease; Oncology; Renal disease; Respiratory Disease; Urogenital Disease

CAR-T · MSC · T-CELL · DC VACCINE · CMV VACCINE · STEM CELLS · AND MORE...

Case Study: Accelerating Patient Access

The challenge

When the Birmingham Children's Hospital (Birmingham Women's and Children's NHS Foundation Trust) were approached by a company to run a haematology ATMP clinical trial, the Trust, seeing the promise of the treatment, were keen to support the trial. However, having no prior experience of advanced therapies, they needed support to enable the creation of the required governance structures and procedures to rapidly set up this clinical trial.

The solution

Through local networks, the team at BCH were made aware of the Midlands and Wales ATTC and introduced to Prof. Phil Newsome. The MW-ATTC have since been able to provide advice and support to the team around the complex regulatory framework. Pharmacists have been linked in to the MW-ATTC network and local individuals who have been able to provide specialist support, to ensure that the team has the required working knowledge in place to safely work with ATMP's and that regulatory requirements are met.

The results

The introduction to the MW-ATTC galvanised the actions required, providing both a road map of the requisite next steps and access to necessary training and knowledge. The availability of multiple resources, including relevant policies and procedures which can be locally adapted has drastically compressed the time taken to progress from initial contact to trial set up.

> **"The MW-ATTC have really helped move things faster at BWC with access to their expertise and teaching materials."**
>
> - Dr Fiona Reynolds, Medical Director of Birmingham Children's Hospital

Making further impact

As a result of the introduction to MW-ATTC and facilitation to this essential knowledge regarding ATMP clinical trials, access to ATMP clinical trials in the Birmingham Children's Hospital has been accelerated and BCH are now able to offer a new service. Although the timeframe for their first gene therapy trial was delayed by the COVID-19 pandemic, they plan to open a GMO trial in Spring 2021 and have already been approached by additional companies looking to partner on future ATMP trials.

ATTC Advanced Therapy Treatment Centres

NHS Birmingham Women's and Children's NHS Foundation Trust

Midlands-Wales Advanced Therapy Treatment Centre

Health Economics

A microanalysis costing toolkit for ATMPs

Download the toolkit and access our handy "how to" guide here

An assessment of the cost benefits of utilising an ATMP versus the cost of standard of care treatment

The production of an economic evaluation of an identified ATMP

White Paper, 'The Methods of Economic Evaluation of Advanced Therapy Medicinal Products'

Economic analysis of tumour storage for a Tumour Infiltrating Lymphocyte

Coming soon: Development of the UK's first Family Reported Outcome Measures Survey for ATMPs

Achievements and Impact

All of our 9 clinical sites are ATMP ready

Contributed 43 original documents to the NHS Readiness Toolkit

Delivery of MW-ATTC clinical readiness programme included the development of a suite of materials ranging from SOPs, guidance documents and training for NHS Trusts.

Patient & Public Involvement & Engagement

Reached over 500

patients via 4 different webinars empowering patients and public to engage with ATMP research.

> **We're really excited that the program has been a success. It has allowed us to build partnerships, build collaborations and expertise; not just within Birmingham, but in the wider UK cell therapy community.**
>
> - Dr. Steve Elliman, Chief Scientific Officer

OrbsenTherapeutics
Redefining Cell Therapy

> **Our informatics solution is a step forward in making a standardised NHS IT system to facilitate ATMP treatments and a NHS IT system to link to cell orchestration platforms. This will allow ATMP treatments to become more mainstream.**
>
> - Prof. Phil Newsome, Director of Midlands-Wales ATTC, University of Birmingham

Commercial Partners

Cytiva is a global life sciences leader with over 8000 associates across 40 sites who are dedicated to our vision to improve access to life-changing therapies that transform human health. As a trusted partner to customers that range in scale and scope, Cytiva brings efficiencies to research and manufacturing workflows, ensuring the development, manufacture and delivery of transformative medicines to patients.

FourPlus are an immersive technology company offering end-to-end software solutions for the life sciences sector. The recent emergence of advanced therapies creates novel workforce and manufacturing challenges. Immersive technology such as Virtual and Augmented Reality (VR & AR) is transforming business practice across a range of major sectors, optimising tech transfer and offering innovative visualisation tools across the operational spectrum. FourPlus combine expertise in life sciences and immersive technology to build solutions that will bring about a step change in the manufacturing of advanced therapies. Our approach unlocks the potential of revolutionary medicines and helps accelerate their delivery to the patients who need them.

Instil Bio, Inc is a global, clinical-stage cell therapy company developing tumor infiltrating lymphocytes (TIL) for the treatment of cancer. We are building on the decades-long foundation of TIL efficacy in treating solid tumors, applying our cell therapy experience and TIL manufacturing platform to bring the promise of TIL therapy to patients in need. Instil Bio has research and cell therapy manufacturing facilities in Los Angeles, CA and Manchester, UK, with corporate offices in Dallas, TX.

Ixaka is a cell and gene therapy company focused on the natural power of the body to cure disease. Our proprietary technologies enhance the inherent therapeutic power of cells by targeting curative cells to the site of disease, and by directly modifying cells within the body to improve their therapeutic action. Ixaka's technologies – concentrated multi-cell therapies and nanoparticle therapeutics – demonstrate potential for the treatment of a broad range of serious diseases across oncology, cardiovascular, neurological and ocular diseases, and genetic disorders.

Miltenyi Biotec is a global provider of products and services that advance biomedical research and cellular therapy. Our innovative tools support research at every level, from basic research to translational research to clinical application. Used by scientists and clinicians around the world, our technologies cover techniques of sample preparation, cell isolation, cell sorting, flow cytometry, and cell culture. Our 30 years of expertise spans research areas including immunology, stem cell biology, neuroscience, and cancer. Today, Miltenyi Biotec has 2,500 employees in 28 countries – all dedicated to helping researchers and clinicians make a greater impact on science and health.

Orbsen Therapeutics is a regenerative medicine company based in Galway, Ireland. Using proprietary technology, we are developing ground-breaking stromal cell treatments to address some of today's most challenging diseases. Stromal cells hold great promise as an alternative to drugs and surgical procedures for treating a wide range of medical conditions including heart disease, arterial disease of the limbs, diabetes complications, arthritis and other inflammatory conditions. The treatment potential is linked to the cells' natural capacity to dampen inflammation and promote healing, repair and regeneration of damaged tissues. Orbsen has discovered and patented a unique method for purifying these rare, therapeutic cells and developing them for clinical use. The cells can be selected from a single donor, expanded and frozen to generate many doses of a high-margin, "off-the-shelf" therapeutic product.

Thermo Fisher Scientific is positioned with resources and global expertise to support customers on the path towards commercialisation. Our global infrastructure enables customers to conduct clinical trials across multiple geographies while providing patients with access to life changing therapies. Cryogenic storage and logistics allow us to configure each site to meet specific requirements of individual clinical trial. We can help navigate many of the unforeseen challenges associated with cell therapy clinical development and commercialisation.

Commercial Partners

TrakCel is a cloud-based Cellular Orchestration Platform (COP) that enables the streamlined delivery of advanced therapies to patients. The platform can be configured to processes defined by the cell therapy manufacturer and records all critical data across the supply chain in a FDA 21 CFR Part 11 and EU Annex 11 compliant manner. TrakCel is a software platform that delivers:

- End-to-end Chain of Identity (COI) management
- Full collection to administration visibility and Chain of Custody (COC) reporting
- Automated scheduling of activities between patient facing clinical and manufacturing sites
- Integration capabilities with ERP, CRM, and other similar systems
- Workflow-driven consistent processing
- Role-based functionality and information access for physicians, nurses, & supply chain partners
- Cloud hosted multilingual platform

World Courier is a global specialty logistics company that designs world-class logistics and supply chain programmes in complete alignment with our customers' business goals. Pharmaceutical companies rely on us because they value the peace of mind that comes with our unsurpassed knowledge, global reach and flawless supply chain execution. Each trusted partnership we form with a customer is deeply rooted in our shared vision of improving global health. With 2,000+ associates in more than 140 offices across the globe, we offer solutions that instil confidence in the on-time, on-temperature delivery of critical products. When trust is absolutely essential, there's only one choice: World Courier.

Visit the MW-ATTC website

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STRATEGIC DEVELOPMENT COMMITTEE

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	07/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	1.7.22	Discussed and reviewed

1. SITUATION

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

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF), which may affect the achievement of the Trust's Strategic Objectives, and the assurances in place to evidence the effectiveness of the management of those risks. This is outlined in section 3.1.
- Summarise the ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework within the Trust, with specific focus on the next three month period up to end of September 2022. This is outlined in section 3.2.
- Update the Committee on the actions agreed in Executive Management Board on this paper which will further feed into the development programme of work. This is outlined in section 3.3.

2. BACKGROUND

2.1 The Trust Board must be able to assure itself that the Trust is operating effectively and meeting its Strategic Objectives. It does this through its internal governance structures, management controls and by providing assurance that its controls are operating effectively, and objectives are being met.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following provides a high level summary of the work undertaken since May 2022, to update the Trust Assurance Framework, support its continued development, articulation and operationalisation within the Trust with specific focus on the next three month period up to end of September 2022.

3.1 **Trust Assurance Framework Dashboard**

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

3.1.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since May 2022 in respect of the following Principal Risks:

			NO REVIEW TAKEN PLACE			
			REVIEWED NO CHANGES			
			REVIEWED AND UPDATED			
			MAR	APR	MAY	JUN
01	Demand and Capacity	**COB**				
02	Partnership Working / Stakeholder Engagement	**CJ**				
03	Workforce Planning	**SFM**				
04	Organisational Culture	**SFM**				
05	Organisational Change / 'strategic execution risk'	**CJ**				
06	Quality & Safety	**NW**				
07	Digital Transformation – failure to embrace new technology	**CJ**				
08	Trust Financial Investment Risk	**MB**				
09	Future Direction of Travel	**CJ**				
10	Governance	**LF**				

3.1.3 The following is a high level summary of the key changes that have been made to the Trust Assurance Framework since May 2022, a full overview of these changes is provided in the Trust Assurance Framework Dashboard at ***Appendix 1:***

- To note, 'Residual' Risk Score is the current score, with the current control environment, and its effectiveness, taken into account. 'Inherent' is the risk score without the control environment operating.

- **TAF 01: Demand and Capacity**

  - **Residual Risk Score** - has remained the same at **12**.
  - **Overall Level of Control Effectiveness -** has been assessed as 'Partially Effective'. Key controls and sources of assurance have undergone detailed review.
  - **Sources of Assurance –** Key controls and sources of assurance have undergone detailed review for both Welsh Blood Service and Velindre Cancer Centre. Assurance ratings have been reviewed and amended.
  - **Action Plan for Gaps Identified –** Following further extensive review the action plan has been developed.
    - In respect of Welsh Blood Service projects are underway both nationally and within Wales to develop digital solutions for the fate of blood donations and to assess the effective use of blood and identify inappropriate use of blood.
    - Work is underway at Velindre Cancer Centre in respect of demand and capacity with the establishment of weekly meetings. Additionally, regular meetings are taking place between the Executive Team and VCC Senior Leadership Team.

- **TAF 02: Partnership Working / Stakeholder Engagement**

  - ***Residual Risk Score*** - has remained the same at **12**.

- ***Overall Level of Control Effectiveness*** – remains unchanged as 'Partially Effective'.
- ***Sources of Assurance*** - ratings have now been reviewed and reported at 'Positive Assurance' for key controls 1.1, 1.3, 2.1, 3.1 and 4.1.
- ***Action Plan for Gaps Identified*** – Following review of the action plan updates demonstrate that all actions have been completed within the timescales

- **TAF 03: Workforce Planning**

  - ***Residual Risk Score*** – has remained at **9** in this report, however during the Executive Management Board review, it was agreed that the collective executive view was this should be increased and the score will be re-assessed.
  - ***Overall Level of Control Effectiveness –*** has been assess as 'Partially Effective'.
  - ***Sources of Assurance –*** have now been assessed and are recorded as 'positive assurance'. Within the action, log third lines of assurance are planned to be reviewed, with a target date of July 2022.
  - ***Action Plan for Gaps Identified –*** Continued review and reporting through committee cycle is planned. Additionally a review of third lines of defence are planned for completion by July 2022.
  - Key Control **C1** - People Strategy has been further updated and discussed during the last reporting cycle. This will provide the strategic framework for effective workforce planning arrangements going forward and an update reflective of this will be included in the next reporting cycle.

- **TAF 04: Organisational Culture**

  - ***Residual Risk Score –*** has remained at **9** in this report.
  - ***Overall Level of Control Effectiveness –*** has been assessed as 'Partially Effective'. However, the action plan includes further development of key controls to an effective level.

- ***Sources of Assurance –*** Sources of assurance have been assessed and recorded as 'positive assurance'. The action plan sets to identify third lines of assurance, as identified in the gaps in assurance.
- ***Action Plan for Gaps Identified –*** The action plan sets out the plan to continue to review and report through meeting cycles, develop third line of defence assurances and develop control effectiveness to an acceptable level.
- Following Executive Management Board discussion in the July meeting, it was requested that the scope and scoring of this strategic risk to be reconsidered in light of the wider organisational change programme which is currently being shaped.

- **TAF 05: Organisational Change / 'strategic execution risk'**

  - ***Inherent Risk Score*** – the risk level has reduced from 16 to **12.**
  - ***Residual Risk Score*** - has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed and remains as 'Partially Effective'.
  - ***Sources of Assurance*** – Review of assurance ratings has been carried out for key controls 1.1 to 1.6 resulting in an overall trend of 'Positive Assurance' emerging.
  - ***Action Plan for Gaps Identified*** – The actions regarding development of enabling strategies were completed on target in May 2022.

- **TAF 06: Quality & Safety**

  - ***Residual Risk Score*** - has remained the same at **15**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective', this is a change from the last reporting cycle, where an effectiveness rating of 'Not Yet Effective' was recorded.
  - ***Sources of Assurance*** – Sources of assurance remain unchanged from the last report.

- ***Action Plan for Gaps Identified*** - has been reviewed, dates reviewed and actions remain on target for completion by target dates.

- **TAF 07: Digital Transformation – Failure to embrace new technology**

  - ***Target Risk Score –*** the risk score has increased from 8 to **12**.
  - ***Residual Risk Score*** - has remained the same at **12**, which is now in line with the target risk level.
  - ***Overall Level of Control Effectiveness*** - has been assessed and remains as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
  - ***Sources of Assurance:*** all key controls remain in place following review. Second lines of defence have been reviewed with assurance ratings allocated.
  - ***Action plan:*** has been reviewed and are on target for completion by target dates.

- **TAF 08: Trust Financial Investment Risk**

  - ***Residual Risk Score*** – has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. This has not changed since the last review.
  - ***Sources of Assurance:*** the risk has been reviewed and no changes made to sources of assurance. Timelines for assurance have moved a quarter, understanding that newly established groups will provide assurance and understanding or further measures if necessary.
  - ***Action plan:*** Actions are on target for completion as expected. Ongoing work continues to understand the relationship between demand and capacity to identify where investment/disinvestment required, which is evolving within Divisions.

- **TAF 09: Carl James – Future Direction of Travel**

  - ***Inherent Risk Score –*** the risk has reduced from 16 to **12.**
  - ***Residual Risk Score*** – has remained the same at **12**.

- ***Target Risk Score*** – has been reviewed and reduced from 12 to **8.**
- ***Overall Level of Control Effectiveness*** - has been assessed and remains unchanged as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
- ***Sources of Assurance:*** the existing key controls remain unchanged since the last review.
- ***Action plan:*** progress has been updated and target dates remain unchanged and on target.

- **TAF 10: Lauren Fear – Governance**

  - ***Residual Risk Score*** – has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Effective'. This remains unchanged since the last review.
  - ***Sources of Assurance:*** the existing key controls in place remain unchanged since the last review.
  - ***Action plan:*** the action plan remain unchanged since the last review. In future reporting cycles, the governance and assurance programmes of work under the organisational design programme will be reflected in the action plan.

3.2 **Key developments, previously noted to the Committee, and planned up to end September 2022 for October Committee reporting**

3.2.1 **Link to Risk Register, Performance Framework and Quality Framework** -

An important step in the development of the Trust Assurance Framework will be to develop the link between the Trust Risk Management Framework, Performance Management Framework and Quality & Safety Management Framework. The connections between these four key frameworks is important to the ability of the Board to more effectively triangulate and assure going forwards.

The first step is to link the Trust Risk Management Framework and Trust Assurance Framework – and this work will be completed over the summer for October Strategic Development Committee reporting.
Following the development of the Trust Performance Management and Quality Management Frameworks, key metrics relating to the strategic risks will also be linked during Q3.

3.2.2 Reverse Stress Testing

Reverse stress testing is the identification of a pre-defined adverse outcome, for instance the point at which an organisation may be considered as failing, and severe, but plausible, risks materialising that might result in this outcome are then explored. This is an important development in the organisation's risk maturity and capability.

This work will be underway and reported to Committee in October. At a high level, it is proposed that this happens in parallel with the review of the overall risk profile, as approaching the macro level risk questions in this way will be a useful tool and input into the annual review.

3.2.3 Link to Strategy Development

In reviewing the profile over the next couple of months, in addition to the reserve stress testing exercise described above, there are two further key suggested inputs:

- Using research and insight on global organisational and health care trends to challenge and support our thinking on macro strategic risks.
- Frame the review in the Trust approved Strategy and Enabling Strategies.

The work will then culminate into the October Committee reporting.

3.2.4 **Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.**

Following discussion and engagement with risk colleagues in other Health Boards across Wales and the identification and assessment of increased automation of the Trust Assurance Framework colleagues in the Datix team are liaising with the Hywel Dda Datix team regarding the development of principal risks within Datix Version 14.

Initial scoping work has taken place and a gap analysis and mapping exercise will take place in July in order to further progress this work.

3.3 **Further developments discussed and agreed in previous reporting period**

In the July Executive Management Board discussion, the following actions were discussed and agreed:

3.3.1 **Actions on specific strategic risks**

As noted in section 3.1, Executive Management Board agreed that the scoring of the strategic workforce planning risk 03 needed to be reviewed, as consensus was the assessment was likely to result in an increased score.

Secondly that the organisational culture risk 04 needed to be linked more specifically to the development of the organisational design work.

3.3.2 **Mapping Trust Assurance Framework to governance cycle**

In line with Board development discussions with Internal Audit and Audit Wales during this period, there should be a clearer link between the Trust Assurance Framework. This will be progressed during the next reporting period. Work will include:

- Ensuring that cycles of business provide appropriate consideration of each of the TAF controls and sources of assurance.
- Mapping the relevant actions into governance cycles.
- Ensure each committee scrutinise progress to address gaps in controls and Assurances within it's scope.

3.3.3 Link to Audit tracker

Executive Management Board also agreed to map the Audit tracker to the third line of defence mapping in the Trust Assurance Framework in order to provide assurance that all current insight, including the impact of open actions on the effectiveness of the control framework, are taken into account.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	Please refer to ***Appendix 1*** for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Committee is asked to:

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

b. **NOTE** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in sections 3.2 and 3.3.

TAF DASHBOARD

DEMAND AND CAPACITY

RISK ID:	TAF 01	We fail to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Aug-22	
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	4	4	16	2	4	8

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

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Blood stock planning and management function WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against national and international standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience and inform and predict any surge demand.	PA	Senior Management Team, COO review and EMB Review, QSP committee and Board.	PA	Welsh Government Quality, Planning and Delivery Review.	PA

TAF DASHBOARD

DEMAND AND CAPACITY

C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangement	Director WBS	X			E	Department Head review with escalation to Director	PA	Performance Report Senior Management Team and EMB Review, QSP committee and Board	PA	Welsh Government Quality, Planning and Delivery Review	PA
C3	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCC (VCS)	X	X		PE	SE Wales Group	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C4	Demand and Capacity Plan for each service area	Heads of Service - Each Area	X	X		PE	Service area operational planning meeting	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C5	Active operation engagement with health boards on demand	Director VCC (VCS)	X	X	X	PE	SLT	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would need digital systems to be in place which are out of WBS control. Projects are progressing externally.	
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inapproprite use if blood, which impacts demand.	
Lack of visibility of granular level planning data and Health Board activity plans to clear backlog at VCC.	
Lack of a formal oversight of capacity and demand management at a divisional level to recognise the complexity of interdependencies of various functions and services at VCC.	Executive Team oversight of the more detailed capacity and demand plans

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

TAF DASHBOARD

DEMAND AND CAPACITY

Action Plan	Owner	Progress Update	Due Date
Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	Project is underway in Cardiff and Vale, supported by WBS. Funding options are being sought	Dec-23
Blood Health National Oversight Group project is underway identifying inappropriate use of blood.	Lee Wong	Gap anaylysis is underway across Health Boards. The IBI lens will be used on this project	Dec-22
Engaging with Health Boards to seek further information on recovery and wider operational plans; such as waiting time initiatives and to formalise a route for planning and managing demand variation, including clinical choices.	Lisa Miller	Email sent via COO to each HB requesting further meetings to discuss data	Aug-22
A formal demand and capcity review meeting has been established at VCC	Lisa Miller	The group has been established and is currently meeting weekly to address the impact on capacity due failure of third party provision. Currently expericencing above usual demand for SACT	Complete
There is a weekly meeting between the Executive Team and Senior Leadership Team established to provide an opportunity for collaboration and oversight for addressing the immediate challenge at VCC	Steve Ham	This meeting is a short term focused meeting pending revised capacity plans	Complete

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Aug-22	
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	4	8

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

GAP IN CONTROLS

GAPS IN ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
1.1	System structures – core cancer services commissioning arrangements		X			PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
1.2	Strategic partnerships which support effective delivery of working/ work programmes			X		PE	Supply and demand reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Regulatory scope re MHRA tbc	PA
3.1	Local Partnership Forum		X	X		PE	Feedback from LPF	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office	PA
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	PA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line and second lines of defence assurance are in place to a certain extent

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE				
	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Linked to developments in ways of working for the Trust, the actions to enhance the effectiveness of the controls will be specifically developed and reported on.	Complete
1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James		Complete
1.3	Development of CCLG leadership and goverancne arrangements: towards Alliance System: agree next steps with CEOs	Carl James		Complete

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Aug-22	
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	3	9	3	3	9	2	3	6

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

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Internal Audit Reports	PA	To be completed as per compliance/ reg tracker update	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/ reg tracker update	PA
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	reports via divisional and committee structures	PA				
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	PA				

TAF DASHBOARD

WORKFORCE PLANNING

C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff meeting to feedback on implementation plan	PA				
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	Recruitment and retention repots via Board	PA				
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Reports via Trust Committee cycle on updates	PA				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports via divisional and committee structures	PA				
C9	Agile Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	PE	Agile Project and Programme Board	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

WORKFORCE PLANNING

1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and the outputs defined to deliver between September 2022 and February 2023.	Feb-23
1.2	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	The Trust has appointed a staff psychologist to support mental health and wellbeing. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform allowing them to be more easily accessible for staff.	Dec-22
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Trust has approved a set of Hybrid working principles. There are now task and finish groups working under the Hybrid working project to develop the operational systems and toolkits that will allow the Trust to fully relaise the benefits of hybrid working arrangements.	Dec-22

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.**
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Aug-22	
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	3	9	3	3	9	2	2	4

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA
C2	Developing Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training Steering Group	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA

TAF DASHBOARD

ORGANISATIONAL CULTURE

C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group	PA				
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes □	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group	PA				
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group	PA				
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health & Wellbeing Steering Group	PA				
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board	PA				
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group	PA				

TAF DASHBOARD

ORGANISATIONAL CULTURE

C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	PA				
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings Education and Training Steering Group	PA PA				
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defence assurance to be completed
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Development of Organisationa Design approach for the Trust to encapsulate both process and cultural elements that need to be inplace to allow the organisation to achieve its strategic goals	Sarah Morley	Stakeholder engagement has taken place on the rationale for this work and an overview of some of the elements of work that may sit within it with the Executive Team, Divisional Senior Leadership Teams and the Board. Work has taken place to identify a Quality management System for the Trust. The scope of the programme and governance arrangements will be developed by August 2022, during which the timelines associated with the main elemtns will be determined.	Aug-22
1.2	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	It has been decided that the Trust Values Project will fulfill a wider brief under the Organisational Design Approach. Interviews are being put in place with Board members as first round of engagement activity.	Dec-22

TAF DASHBOARD ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.		
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations		
NEXT REVIEW	Aug-22			

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

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
1.1	Trust strategy to provide clear set of goals, aims and priorities	Carl James	x				Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.2	Integrated Medium Term Plan to translate strategy into clear delivery plans	Carl James	x				Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.3	Performance reporting in place to ensure delivery of required quality/performance in core service	Carl James	x		x		Executive Management Board review/ patient and donor feedback	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA

TAF DASHBOARD ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x			Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review /	PA	Audit Wales	PA
1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x				Executive Management Board review / staff feedback	IA	Strategy Committee/QSP/Internal Audt Review / CHC	IA	Audit Wales	IA
1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x					IA	Internal Audt Review	PA	Audit Wales/HIW	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented	
Not all supporting strategies approved by the Board	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in May 2022 (on track for May 26th 2022). Trust strategy and enabkers developed and approved (with launch in Sept 2022)	Complete
Develop IMTP to provide priority for action and application of resource	Carl James	Final draft going to Board for approval March 2022	Complete
Information requirements being scoped	Cath O'Brien	First phase to support new performance measures (on track for September 2022)	Sep-22
Implement revised performance management framework	Carl James	New scorecards being finalised for implementation (on track for September 2022)	Sep-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Aug-22	Goal 1		
EXECUTIVE LEAD	Nicola Willams			

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
5	5	**25**	3	5	**15**	2	5	**10**

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE
C2	CIVICA pt/donor feedback system being implemented	Nicola Williams			X	PE
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Staff feedback	IA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
Patient/Donor Feedback	IA	Quality, Safety & Performance Committee	IA	HIW Inspect	Not Assessed
15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
EMB	IA			Professional bodies	Not Assessed
Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
PMF	IA				Not Assessed

TAF DASHBOARD

QUALITY AND SAFETY

C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE	Perfect Ward audits	IA				
							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews	IA				
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			PE		IA	Internal Audit Reviews	Not Assessed		

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework not finalized due to pandemic	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality & Candour guidance still under development	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The Trusts performance framework does not currently adequately monitor service level to board quality, safety, outcome and experiential measures
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires establishment - to operationally pull together all stands and feed into EMB & QSP

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	Jul-22

TAF DASHBOARD

QUALITY AND SAFETY

1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Paul Wilkins Alan Prosser	Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team. OCP Process has commenced. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	Aug-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Will be developed once Framework finalised	Jun-22
1.4	Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Will be established once OCP completed	Jun-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Training arranged for March - delayed due to Omicron	Jun-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley		Jun-22
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Planned for March 2022	Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23
1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and established for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23	Jun-22
1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	Jun-22

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.									
LAST REVIEW	Jun-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe									
NEXT REVIEW	Aug-22										
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	3	4	**12**	3	4	**12**	

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE	Staff feedback	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C4	Training & Education packages for donors, patients	Chief Digital officer	X			PE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA	Wales Audit Office	PA
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PA
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office/Centre for Digital Public Services	PA
C7	Digital inclusion – in wider community	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C8	Opportunities for digital career paths	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	Trust digital governance reporting	PA	Wales Audit Office	PE

TAF DASHBOARD

DIGITAL TRANSFORMATION

C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PE
C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PE
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital officer			X	PE	Review via Divisional SMT / SLT	PA	Review via EMB / Trust Board	PA	Wales Audit Office	PE

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2
	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls, as per action 1.1

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

DIGITAL TRANSFORMATION

1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (on track for July 2022) (new CDO commences on 1st July - will pick up on appointment)	Jul-22
1.2	December Strategic Development Committee	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (new CDO commences on 1st July - will pick up on appointment)	Oct-22

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.									
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations									
NEXT REVIEW	Aug-22	**Goal 2**									
EXECUTIVE LEAD	Matthew Bunce	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		3	4	**12**	4	4	**16**	3	4	**12**	

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives and Senior Management Teams	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas. Welsh Government and Commissioners engaged on current and future consequences.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams discretion and not formally supported by a framework for decision making.

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Support the embedding of investment framework within Divisions	David Osborne	Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.	Jul-22
1.2	Review of contracting model for impact of COVID related measures	David Osborne	Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.	Jul-22
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Jul-22

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.								
LAST REVIEW	Jun-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Aug-22	**Goal 2**								
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		4	4	**16**	3	4	**12**	3	4	**12**

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			PE	Executive Management Board review	PA	Strategic Development Committee	PA	Audit Wales Reviews	PA
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE	Executive Management Board review	IA	Strategic Development Committeen and performance management framework	IA	Audit Wales Reviews	PA

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services	Cath O'Brien	x			PE	Executive Management Board review/ patient and donor feedback	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C6	Change in strategic workforce plan to recognize/address any new leadership/clinical/management skills related to strategic growth	Sarah Morley	x			PE	Executive Management Board review	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C7	Refresh of Investment and Funding Strategy	Jacinta Abraham	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management	IA	Audit Wales/External Research organisations & Welsh	PA
C8	Development of commercial strategy	Matthew Bunce	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management Framework	IA	Audit Wales/External Research organisations & Welsh Government	PA
C9	Attraction of additional commercial and business skills	Matthew Bunce		x		PE	Executive Management Board review	IA		IA	Audit Wales/External Research organisations & Welsh Government	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of clinical and scientific strategy	
Commercial expertise within the Trust	
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capability to leverage the strategic oppor	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James	On track for May 2022. The overarching Trust Strategy "Destination 2032" was approved in the January Trust Board. The Enabling Strategies were subsequently approved, as outlined below, in the May 2022 Trust Board.	COMPLETE
1.2	Board decision on strategic areas of focus/to pursue	Board	Final enabling strategies on track for may 2022 - allowing prioritisation to occur in future IMTPs. Trust Enabling Strategies were approved by the Trust Board in May 2022.	COMPLETE
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board decisions)
1.5	development of clinical and scientific strategy	Jacinta Abraham		tbc
1.4	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions)

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.			
LAST REVIEW	Jun-22	1 - Outstanding for quality, safety and experience			
NEXT REVIEW	Aug-22	**Goal 1**			
EXECUTIVE LEAD	Lauren Fear	**RISK SCORE (See definitions tab)**			

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	4	**8**

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

KEY CONTROLS

SOURCES OF ASSURANCE

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

TAF DASHBOARD

GOVERNANCE

								Trust Board		Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial assurance) Audit Wales review outcomes of report as part of Annual Report - Accountability Report	PA
C4	Board Development Programme	Lauren Fear	X			PE	Programme established PA	IA	Independent Member Group repurposed and second meeting now held. Further embedding through 2022/23	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA		PA	Audit Wales review of Quality Governance Arrangements	PA

TAF DASHBOARD

GOVERNANCE

C6	Quality of assurance provided to the Board	Lauren Fear	X			E	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role. IA	IA	Trust Board assessment via formal annual and additional effectiveness review exercises. IA	IA	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
None	Third line of defence in respect of C4 – Board Development Programme: no course of action is proposed

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.		Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Complete
Ongoing input from the Independent Members via the repurposed Integrated Governance Group		Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete

STRATEGIC DEVELOPMENT COMMITTEE

NUFFIELD TRUST INDEPENDENT ADVICE – A PROGRESS UPDATE

DATE OF MEETING	07/07/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
TCS Programme Delivery Board Executive Management Board (Shape)	14/06/22 22/06/22	Noted Noted

ACRONYMS	
CCLG	South East Wales Cancer Collaborative Leadership Group
FBC	Full Business Case
LHBs	Local Health Boards
NT	Nuffield Trust
OBC	Outline Business Case
VT	Velindre University NHS Trust

1. PURPOSE

1.1 The purpose of this paper is to provide an update **as at June 2022** on progress against the recommendations contained within the Nuffield Trust (NT) report[1] published on 1st December 2020.

1.2 The Nuffield Trust report set out 11 recommendations for Velindre University NHS Trust and Health Board (HB) partners to consider in securing planned and sustained improvements in cancer services in the immediate, medium and long-term.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The current position against each of the recommendations is set out in the 'Progress' column in Annex A. **Updates for June 2022 are illustrated in *red text*.**

2.2 In March 2022, a joint update on progress one year on from the publication of the Nuffield Trust advice was also produced. The document was been reviewed, updated and endorsed by Velinde's four Health Board commissioning partners, which was important given the collective regional ownership of the majority of the actions.

2.3 At the Collaborative Cancer Leadership Group (CCLG) meeting in May 2022, a process was agreed for collectively updating the Nuffield Progress Report on an ongoing basis as a south east region. This is to ensure the full breadth of activities across all three health boards and Velindre University NHS Trust are fully captured. This will commenced from July (subject to diary availability).

2.4 Both the collective '1 Year On' update and the attached progress report will be used as a basis for the regular updating process described above.

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:

[1] *Advice on the proposed model for non-surgical tertiary oncology services in South East Wales* (Nuffield Trust, December 2020)

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 Strategic Development Committee is asked to **NOTE** the progress update.

Annex A Nuffield Trust Recommendations: Progress Update (June 2022)

	Recommendation	Key actions	Lead	Target date	Progress
1	The planning process for all South East Wales cancer services needs to be reviewed and its coordination improved, with the development of a common dataset and planning approach put in place. Steps have been taken to support this and it is going to be very important that the CCLG is effective – this will help to fill the strategic gap in the planning of cancer services that has existed across South East Wales. There are some lessons from the development of the more successful cancer alliance models in England that could be followed. These take responsibility not only for the planning of cancer services but also for leadership and performance management.	**Developing the cancer system (alliance approach)** Agree strategic approach for SE Wales e.g. Alliance or Vanguard model	HBs/VUT	Tbc following workshop	• CEOs/CCLG all agree on principle of the approach • Regional workshop held on 29/4 facilitated by the Nuffield Trust with broad exec attendance. • Agreed need for change and a series of priorities for action • VUT Director of Strategic Transformation, Planning & Digital is initially coordinating actions across the regional Directors of Planning
		• Develop approach/plan to evolve CCLG e.g. programme/ governance/resources	HBs/VUT	Tbc following workshop	• Plan now in development to be completed by Sept 2022 CCLG. • Initial resource requirements being scoped as part of plan. • SE London Cancer Alliance agreement to informally support & sharing learning
		Developing strategy for South East Wales • Initial discussions across region/scoping • Establish arrangements for strategy development • Develop plan/ identify resources/ arrangements etc.	HBs/VUT	Apr 2022 (this date is subject to system decisions at workshop in April 2022	• System Workshop held on 29/4 • Agreement in principle of benefits of SE Wales Cancer Strategy. • Initial priorities agreed • Scoping of initial resources requirements underway

	Recommendation	Key actions	Lead	Target date	Progress
2	Full co-location would have advantages but is not practical for a significant period of time. However, action is required soon to deal with the issues with the estate and linear accelerators at the VCC.	Secure approval of Commercial Approval Point (CAP) 1	VUT	Feb 2021	• Complete
		Secure approval for OBC for new Velindre Cancer Centre	VUT	Mar 2021	• Complete
		Secure approval of Commercial Approval Point (CAP) 2	VUT	Aug 2021	• Complete
		Procurement and Pre-Qualification Questionnaire (PQQ) of bidders	VUT	Jul 2021	• Complete
		Run Competitive Dialogue and award contract	VUT	Sep 2021	• Competitive Dialogue closed and Invitation to Submit Final Tender (ITSFT) issued to bidders on 27/5. • Evaluation process underway with recomedation to Trust Board planned for 20th July 2022
		Secure approval of Commercial Approval Point (CAP) 3	VUT	Feb 2022	• Complete
		Secure approval of Commercial Approval Point (CAP) 4	VUT	May 2022	• Complete
		Construction of nVCC	VUT	Dec 2024	• On track
		Secure approval for OBC/FBC for Integrated Radiotherapy Solution for SE Wales	VUT	May 2022	• Final IRS tender evaluation complete and outcome report approved by Board in May 2022. Standstill letters issued

	Recommendation	Key actions	Lead	Target date	Progress
					to bidders. Final OBC/FBC issued to WG.
3	In the near future, each HB needs to: a) Develop and implement a coordinated plan for: - analysing and benchmarking cancer activity against their areas	HBs required to develop: • Benchmarking plan etc.	HBs/ VUT		• HBs have a range of benchmarking in place for clinical services. Further work required for key system markers. To be considered as part of system workshop action plan.
	- advice and decision support from oncology for unscheduled cancer inpatient admissions via A&E	• develop a revised target operating model for non-surgical tertiary oncology services including alignment of the AOS/ambulatory care models	HBs/VUT		• AOS business case approved and Phase 1 implementation underway.
	- acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission an option on a district general hospital site if needed, complemented by the Velindre@ ambulatory model,	• **Phase 1:** V@UHW: scoping commenced Feb 2021 - Archus consulting commenced to support - Develop Programme Brief and establish governance - Establish project work streams and run clinical design workshops:	CAV and VUT	Feb 2021 May 2021 Jun; Sep; Oct 2021	• Complete • Brief complete and agreed May 2021. • Joint Planning Manager post appointed (CAV& VUT) to support the V@UHW work.

	Recommendation	Key actions	Lead	Target date	Progress
	bringing models for haemato-oncology and solid tumour work together	**i. RD&I workstream**	CAV and VUT	Oct 2021	• RD&I – Final Cardiff Cancer Research Hub Clinical Output Specification (COS) complete. • Endorsed at CCLG (Oct 2021) for detailed business case development work to commence. • COS signed off by all partners (endorsed by Velindre Trust Board Jan 2022). • All partners agreed initial phase 1 funding to support moving solid tumor trials to UHW • Project Board established and well attended by all tripartite partners • Agreed funding to commission external support to develop the Funding Strategy for the Hub
		ii. unscheduled care workstream;	CAV and VUT		• Acute / Unscheduled Care Data analysis complete • Acute / Unscheduled Clinical Design Workshop (Sept, Oct ’21 & Jan ‘22). • Integrated non-elective cancer pathway between UHW and VCC developed via clinical workshops. • SOS Transfer pathway policy for Adults has been updated

	Recommendation	Key actions	Lead	Target date	Progress
					• Paediatric Transfer Policy now being developed • Transfer / referral handover documentation developed to support effective communication between CAV & VCC • Patient information leaflet developed re transfer to HB from VCC (incl. safety netting info) • Ongoing Improvement work to strengthen VCC 24/7 Helpline • Joint clinical governance framework being developed to ensure transfer pathway continues to be reviewed (patient experience & timeliness/appropriateness of transfer) • Further Improved Clinical Decision Making (ICDM) training is being commissioned from HEIW
		ii. haematology and oncology workstream - Redesign pathways - Develop business proposals/implementation plans	CAV and VUT	Dec 2021	• Scope and ToR agreed • Limited progress due to capacity constraints. • Joint Planning Post's initial priorities will be Haem Onc (commencing in post 4th July)

	Recommendation	Key actions	Lead	Target date	Progress
	Consider the lessons of Covid-19 in terms of remote access for patients and the remote provision of advice, multidisciplinary team meetings and other methods for improving access to specialist opinion.				• Ongoing as part of post COVID lessons learnt.
4	The new model should not admit those who are at risk of major escalation to inpatient beds on the VCC. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to the VCC therefore need to be revised to reduce the risks associated with acutely ill patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review	Agree changes to current admission criteria and other required internal VCC changes	HBs/VUT	May 2021	• **Complete:** Internal VCC operational changes completed, delivered via Velindre Futures. Retrospective audit against revised admissions criteria completed and final results shared at Jan clinical design workshop.
		Changes in operational flows of small number of acutely unwell patients to DGH Phase 1: V@UHW	CAV/VUT	Oct 2021	• Develop Acute Deteriorating Patient Pathway between VCC & UHW • Joint formal pathways for USC and IO (including triage) are being developed with CAV clinical teams. Pathway document drafted. • Formal transfer pathways for unwell/acutely unwell patients developed with CAV clinical

	Recommendation	Key actions	Lead	Target date	Progress
					teams. Transfer document for SOS/Unwell patients is in place. *(see also Rec 3)*
		Phase 2: V@AB and V@CTM	CTM/AB/VUT	Mar 2022 (initial model) – up to 2024 for new infrastructure	• V@CTM – work not started. Approval of AOS Business Case. • V@AB – VUT representation on AB Project Group developing Cancer Unit at Nevill Hall Hospital (NHH), alongside Radiotherapy Satellite Centre.
		Development of regional Acute Oncology Service (AOS):	CTM/AB / VUT/CAV	Oct 2021	• **Complete** • Business case approved by CAV, AB, CTM (revised local version) and Velindre. • SRO confirmed as Exec Director of Planning, ABUHB • Regional Project Manager in place to support implementation.
		Development of AOS project brief/governance	CTM/AB / VUT/CAV	2021	• Complete
		Development of AOS clinical model	CTM/AB / VUT/CAV	2021	• Complete
		Development of AOS proposal / business case	CTM/AB / VUT/CAV	2021	• Complete
		Approval of AOS business case	CTM/AB / VUT/CAV	2021	• Approved by all VUT, CAV, ABHB and CTM (May 2022) Boards
		AOS Implementation	CTM/AB / VUT/CAV	2022 Ongoing	• CTM Board approved AOS business case on 31.05.22

	Recommendation	Key actions	Lead	Target date	Progress
					• MUO/CUP Cancer Nurse Specialist appointed • ABU 8a post interviews had an unsuccessful outcome for the second time – advice sought from WOD. • ABU B6 CNS advertised (May'22) • Education T&F group first meeting (May 22) –agreed within year spend and prioritise new staff • Specialist Oncology and Digital T&F groups first meeting (May'22) • Networking Day (June '22) at Bute Park Conference Centre
5	To support recommendations 4 and 5, and the research strategy, a focus on cancer including haemato-oncology and a hub for research needs to be established at UHW. There would be advantages to this being under the management of the VCC, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of	• Develop Velindre Research strategy	CAV/VUT	Apr 2021	• Complete
		• Identification of options/solutions to develop a hub at existing UHW	CAV/VUT	Apr 2021	• Complete
		• Development of clinical model for research V@UHW	CAV/VUT	Jun 2021	• Complete
		• Develop business proposals/implementation plans	CAV/VUT	Oct 2021	• On Track – see above Rec 3
		• Implementation	CAV/VUT	Oct 2021	• On Track – see above.

	Recommendation	Key actions	Lead	Target date	Progress
	co-location – access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity.				
		Exploration of strategic solution for long-term V@ facility in UHW2 and alignment of strategic capital business cases	CAV/VUT	Tbc – awaiting confirmation of UHW2 timelines	• On Track. Project Board in place to oversee implementation plan if/when governance approvals received.
6	The ambulatory care offer at the VCC should be expanded to include SACT and other ambulatory services for haemato-oncology patients and more multidisciplinary joint clinics. Consideration should be given to expanding a range of other diagnostics, including endoscopy, to create a major diagnostic resource for South East Wales that will be able to operate without the risk of services being disrupted by emergencies and which would also protect these services in the case of further pandemics.	• Review of current arrangements to determine what further opportunities exist for change in patient flows for : (i) SACT (ii) Diagnostics.	See Rec 3 & 4	See Recs 3 & 4	• Haematology SACT to be considered as part of V@UHW. Initial priority for Joint Project Manager once in post (4th July). • Further wo
		• Development of regional operating model (as per recommendation 3) for: (i) V@UHW (ii) V@AB (iii) V@CTM	See Rec 3 & 4	See Rec 3 & 4	(i) **V@UHW** – see Rec 3 & 4 (ii) **V@AB –** SACT Outreach discussions underway with provision at NHH (iii) **V@CTM** – Work included in outreach and clinical projects, but further work required. See also AOS business case (complete)
7	The Velindre@ model needs further work to describe how it will operate, its interface with acute services and its relationship to the wider pattern of ambulatory care. This should include the integration and	• Development of regional operating model developed for non-surgical tertiary cancer services which finalises V@ requirements for at home/outreach care		See recs 3 & 4	• Further work required on regional operating model, beyond V@UHW • See also recs 3, 4 and 6

	Recommendation	Key actions	Lead	Target date	Progress
	development of other ambulatory therapeutic services such as dietetics, occupational therapy, physiotherapy, psychological therapy and speech therapy.	• See Recs 3 & 4			
8	The development of a refreshed research strategy is a priority and further work is required to fully take advantage of the networked model.	• Development of Velindre Research strategy	VUT	Apr 2021	• Complete
		• Alignment of Research, Development & Innovation strategies across South East Wales	HB/ VUT	May 2021	• Complete – regional ToR agreed to by CCLG
		• Alignment with development of service/infrastructure: (i) UHW acute/research hub (ii) Velindre@ AB (iii) Velindre@ CTM	 C&V/VUT AB/VUT CTM/VUT	Oct 2021	• Complete (phase 2 – implementation plan being developed)

	Recommendation	Key actions	Lead	Target date	Progress
9	Organisational development and other work to create a successful cancer network is going to be required but has not featured much in our conversations for this report.	• Development of regional workforce plans	HBs / VUT		• National cancer workforce discussions with HEIW and partners – national work in place • Regional workforce approach agreed as a priority at CCLG workshop in April 2022 • No regional plan developed to date
10	Flexibility in design is going to be important both for the new VCC and for whatever is developed at the new UHW due to the rapid change in the nature of treatment and research.	• Flexibility built into new Velindre Cancer Centre specification	VUT	31sh Mar 2021	• Complete
		• Strategic review of future opportunities across the region in advance of proposed developments e.g. community diagnostics strategy; local cancer plans; split acute/elective sites; proposed UHW2 development etc.	HBs / VUT		• Initial high level scoping discussions undertaken • Further scoping to be undertaken regionally • Awaiting confirmation of UHW2 timelines
11	There are future strategic development opportunities provided by the development of a new VCC and a proposed UHW2. Working together over the 15- to 20-year window, the health system should look to exploit these development opportunities in light of future service needs.	• Establishment of strategic planning capability under the leadership of the CCLG to identify service/infrastructure requirements in planned infrastructure	HBs / VUT	tbc	• CCLG system workshop in April (see Rec 1) identified a series of regional priorities. CCLG supportive of the need to move towards a strengthened Cancer Alliance type structures to support strategic planning capability. • See also rec 1
		• Partnership between Cardiff ULHB, Velindre University NHS			• Awaiting confirmation of UHW2 timelines

	Recommendation	Key actions	Lead	Target date	Progress
		Trust and Cardiff City Council on master planning activities in North Cardiff			

STRATEGIC DEVELOPMENT COMMITTEE

UNIVERSITY DESIGNATION SHOWCASE

DATE OF MEETING	7th July 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Cover paper - Lauren Fear, Director Corporate Governance & Chief of Staff – Case Studies led by Prof Mererid Evans and Chloe George.
PRESENTED BY	Lauren Fear, Director Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	22.6.22	*Noted*

ACRONYMS	

1. SITUATION

– UPDATE OVERVIEW REGARDING UNIVERSITY DESIGNATION STATUS

1.1 The Trust participated in a Triennial review and presentation of it's University status in the summer of 2021. It was communicated by Welsh Government at that stage that the means by which there would be oversight of each Health organisation's university status would be developing from the set piece triennial review and presentation process into the emphasis instead being on embedding the principles of the university status throughout the organisation.

1.2 Welsh Government have advised that there will be a report required by each organisation in September to summarise the progress made in this respect. The Director Corporate Governance & Chief of Staff has met with the Welsh Government team for an initial briefing meeting of this requirement and scope of the report. It is proposed that a steering group is established, with representation from across the Trust by division/ function and also across the three pillars of university designation: Innovation, Training and Education and Research and Development. Links with our academic and wider strategic partners is also being considered. The proposed membership and structure of this group will be brought to the July Executive Management Board Shape meeting. This will also include consideration of the outline and approach to the September report submission to Welsh Government. The report will be shared with the Strategic Development Committee in October.

2. KEY MATTERS FOR CONSIDERATION

- UPDATE REGARDING UNIVERSITY DESIGNATION WORKSHOP 30TH JUNE

2.1 Further to the overall approach to long-term approach to embedding the culture and principles of University designation across the Trust, the purpose of this paper is to provide an update to the Committee on the Workshop Event being held on 30th June.

2.2 Welsh Government are facilitating the day and have provided the following summary:

- *100 participates will attend from senior positions within organisations who are part of or intending to join University designation process from across Wales.*

- *The emphasis of the workshop is to provide an opportunity to exchange emerging experiences among authorities. Sessions will include an update on progress;*

discussions on tackling 'Wicked Issues' that inhibit progress; feedback on ways to further develop the University Designation Programme; and an opportunity to consider accelerator steps in each participating organisation.

2.3 Participants have been invited to submit two case studies. These are includes as Appendix 1 and 2**.**

Appendix 1: Cancer Research & Development Ambitions 2021-31 with a focus on the Tripartite Partnership Approach for Cancer Research. This is being presented by Professor Mererid Evans and Prof Awen Gallimore from Cardiff University. They will be supported by colleagues at the event from Cardiff & Value UHB.

Appendix 2: The Welsh Blood Service Component Development Research Laboratory. This is being presented by Chloe George.

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 Strategic Development Committee are asked to **DISCUSS** the content of this report.

Cancer Research & Development Ambitions 2021-31

An overarching Cancer Research & Development Ambitions 2021-31 developed by multidisciplinary research leads from the Cancer Centre, University partners and Patient and Public representatives received approval from the Velindre University NHS Trust Board in March 2021.

These describe our vision, mission and aims for future Cancer Research at Velindre that will be delivered through research in 4 interconnected strategic themes.

Our vision is to work with patients and partners to design and deliver excellent research that improves the survival and enhances the lives of patients and their families.

Our mission is to become a leader in cancer research nationally and internationally, transforming the culture of our organisation into one where every patient, family and staff member who wants to engage with research has the opportunity to do so.

To enable this, we will work with our NHS and academic partners, with a shared strategic focus and collaborative ethos.

Our Aims are to:

- Enhance patient experience and care
- Improve patient outcomes and reduce variation
- Accelerate the implementation of new discoveries into the clinic
- Demonstrate the impact of our research on patients and the NHS
- Build research capacity and capability at Velindre & across SE Wales.

Our Research Themes:

Putting patients first and at the centre of everything we do: patients will help set the research agenda and we aim to increase opportunities for patients and their families to take part in research, so that within 10 years most of our patients are offered research and innovation opportunities at some point in their cancer journey.

Advancing new treatments, interventions and care: We will lead and take part in well-designed Clinical Trials and other research studies, providing the evidence base required to bring new, improved treatments and interventions into the clinic to enhance patient care. Research that is led from Wales will be prioritised and new infrastructure for research delivery will be developed, including a Tripartite Cardiff Cancer Research Hub for Early Phase and Translational research delivery on the University Hospital of Wales (UHW) site and a firm footprint for research at the new Velindre Cancer Centre, particularly to enable cutting-edge radiotherapy research.

Driving translational research through connecting the laboratory and clinic: We will work closely with our academic (university) partners to enable translational ('bench to bedside') research, bringing new discoveries (novel drugs, imaging techniques and/or technological advances) through from the laboratory to the clinic to benefit patients. We will also enable reverse translation ('bedside to bench') research where patient samples/scans and/or data are taken back to the laboratory to generate new knowledge. Developing Clinical Academic posts that link across clinical-academic boundaries will be key to success in this theme.

Embedding research and innovation within the organisational culture: We will establish an organisational culture that values research and build capacity and capability within the multi-disciplinary workforce, providing dedicated ring-fenced time and training opportunities for staff from all disciplines who wish to engage with research. The appointment in 2020 of a Velindre Professor of Nursing and Interdisciplinary Research is important in this endeavour.

Focus in the showcase event on the Tripartite Partnership Approach for Cancer Research

Velindre University NHS Trust (VUNHST), Cardiff and Vale University Health Board (CVUHB) and Cardiff University (CU) have a shared vision and ambition for leading world class cancer research. Results of such research leads to benefits to cancer patients and the public, also bringing significant economic benefits to Wales

Over the last 12 months a ground-breaking strategy has been developed and planning commenced to develop a Cancer Research Hub that is located on the University Hospital of Wales site involving a tripartite partnership approach between CVUHB, VUNHST and CU.

Background

Clinical and translational oncology research is a vital to advance cancer treatments for different cancers and is central for leading, discovering and improving cancer treatments for people both within Wales and across the world.

During the last three years more complex cancer trials are emerging due to precision medicine and the changing landscape of the novel therapies that are being developed, for example:

immunotherapy, virotherapies and cellular therapies. Many of these studies require access to ITU/HDU facilities.

Linked with Transforming Cancer Services in South East Wales, the Nuffield Trust report (1st Dec 2020) set out recommendations that were considered by the South East Wales NHS regional partners regarding the cancer clinical model. The report included research recommendations for and in particular identified that a "research Hub at UHW needs to be developed alongside an enhanced Velindre supported Acute Oncology Service which should work closely with Haemato-oncology and other specialities, this would enable phase 1 and other trials to take place at UHW where ITU support is available " and "the research Hub offers opportunities for closer working with University which will be increasingly important in several areas."

Developing a cancer research Hub aligns with ambitions set out in All Wales Cancer Research Strategy (awaiting publication) and within VUNHST's Velindre Futures Overarching Cancer Research and Development Cancer Ambitions 2021-2031. The Hub proposal has been endorsed by the South East Wales Cancer Collaborative Leadership Group and work associated with the Hub is identified as a priority in both CVUHB's and VUNHST's 2022-25 IMTP.

Oversight and governance arrangements are managed within the VUNHST, CVUHB and CU Partnership Boards with key senior leaders from the three organisations driving the initiative in a shared Hub Project Board.

Description of the Hub

The main aims of a tripartite Cardiff Cancer Research hub will be to build on partner's research to:

- **increase patient access to cutting edge research,** including Early Phase and Advanced Therapies trials for solid cancer and haematological malignancies
- Enable collaboration between academic scientists and NHS clinicians to bring new discoveries through to the clinic by **strengthening the translational pipeline**
- Develop a **focus for cancer research** excellence in Wales to enhance the collective reputation and attract future funding, partners and staff.

The Hub will:

- Deliver a portfolio of cutting edge, high and intermediate risk Early Phase and Advanced Cellular and non-Cellular Therapies and complex clinical trials for solid cancer and haematological malignancies, with access to HDU/ITU and specialist services (e.g. surgery, cardiology, immunology, gastroenterology) to manage the complications of therapy.
- Enable collaboration and cross working between solid cancer and haemato-oncology research.
- Include clinical space (12 treatment beds and 12 treatment chairs), office and meeting space, with direct links to the laboratory, biobank, surgery, interventional radiology and other specialities.

- Bring together an integrated, multi-disciplinary clinical academic workforce, developing future Welsh led research and research leaders. Inspiring the next generation of cancer researchers in Wales supported through education and training.
- Promote new research opportunities to other partners including other Health Board partners and building new research partnerships within and beyond Wales.
- Produce high quality research measured by research activity data, publications, impact, income, increased research impact cases and Research Excellence Framework (REF) status
- Improve income generation into Wales (commercial trials, industry investments, grant awards etc)
- Enhance Wales' research competitiveness at UK level, improving research status and reputation for all partners involved.

The Implementation of the Hub requires a phased approach which includes:

- *Immediate - 0 mth to18 mths - using existing facilities at UHW*
- *Intermediate - 18 mths to 5yrs - growth phase and the establishment of Hub infrastructure*
- *Long term - 5yrs to 10yrs - consolidation phase including reinvestment of commercial revenue.*

Progress to Date

Despite the NHS constraints associated with the pandemic, excellent progress has been made. The Hub Project Board meets monthly, rotationally chaired by CVUHB, CU and VUNSHT. This work is overseen by the CVUHB, CU and VUNHST Partnership Board. Operational working groups are being developed. Outcomes include:

- A joint proposal for the Hub has been developed with partners which describes the intent and associated infrastructure and workforce needed. This proposal is formally signed off by VUNSHT (subject to Heads of Terms being in place with partners) and the Hub proposal is going through the governance processes within CVUHB and CU.
- Discussions have commenced with key Welsh cancer research organisations whose strategies align to the research associated with the Hub regarding partnership opportunities.
- CVUHB have provided access to 2 research beds in the Clinical Research facility including access to beds in high dependency equivalent facilities.
- Short-term monies have been secured from VUNHST, enabling the immediate phase (0 - 18mths) of the Hub to begin which includes provision of workforce to deliver solid cancer trials at the Clinical Research Facility. Job descriptions have been developed and posts are moving through the recruitment process.
- Discussions are well underway with the Joint CavUHB and CU Research Office, regarding opportunities for VUNSHT to work more closely
- Business cases are in development both in VUNSHT and CU with the aim to secure a full time Clinical Academic post.
- A robust investment and funding strategy is being developed, which is supported and agreed by all partners

The Welsh Blood Service Component Development Research Laboratory

Establishing a Component Development Research (CDR) function has given the Welsh Blood Service (WBS) the capacity and facility to achieve its ambition to become a centre of excellence, opening opportunities for us to collaborate with public and private sector organisations, as well as to be strategically aligned with other UK & European Blood Services.

Background

Until very recently WBS has attempted to deliver research and development of blood components within operational areas, with new components being manufactured in the live environment and tested within the QA laboratory. This has resulted in:

- a limited ability to deliver change
- predominantly only regulatory changes being implemented
- some components not being manufactured to best-practise standards (for example granulocytes and washed red cells), when bench-marked with other blood establishments
- WBS being the only blood service within UK & Ireland (with the exception of NIBTS) that does not have a dedicated component development function.
- Limited ability to horizon scan enabling future-proofing and strategic planning
- Lack of involvement in the development of new scientific and technological advances

In 2019/20 work commenced to define, plan and implement a dedicated facility with people and equipment focussed on research into the manufacturing and clinical use of different blood components.

The Component development Laboratory

Creating a CDR function has provided WBS with the dedicated facilities and resources to:

- Respond proactively and flexibly to changes in regulation and specifications for blood components.
- Review the current blood component portfolio for WBS, identifying areas to improve product quality and increase manufacturing efficiency.
- Identify opportunities to streamline the supply chain
- Scrutinise current manufacturing processes, ensuring that the quality of all current blood components are optimised
- Provide assurance to the organisation that the manufacturing processes are producing components able to give maximum possible efficacy to patients.
- Develop and implement processes to manufacture novel blood components in line with regulation and specification changes

- Link with clinical users of blood components to understand changing requirements for blood components in terms of improving clinical outcomes, changing demographics and personalized medicine
- Drive a culture of partnership and evidence-based medicine across NHS organisations.
- Engage with industry and commercial partners to collaborate on innovation and research projects with the potential to generate income
- Link with academic partners to provide innovative PhD opportunities, strengthening and supporting the Velindre Trusts University status and increasing WBS publications
- Horizon scan for the future of blood component therapy, including exploring and testing new technologies for the manufacture of blood components
- Be an education resource for scientists, providing research projects for all levels of academic study from BSc level to PhD. WBS has been investing in collaborative research through KESS studentships at Welsh Universities for some time and the CDR laboratory would be a catalyst to help develop some of the outputs of this research into operational and clinical benefits for WBS and our service users.
- Enable WBS to contribute to scientific research, on an equal footing with other blood services
- Contribute on a National level to increasing capacity for health research in Wales; in line with Welsh Government, policies, promoting inward investment to Wales.

- The Implementation of the CDR Laboratory followed a phased approach which envisaged:

  - Year 1: Delivering on small efficiency and quality improvements to components, for e.g. manual washing of red cells, neonatal split Fresh Frozen Plasma (FFP) & Cryoprecipitate. Designing and building laboratory, purchasing and validation of manufacturing and testing equipment.

  - Year 2: Further develop research capability in terms of available assays; scope and commence novel component work plan to include storage lesion research (for e.g. cold platelets). Link and develop relationships with clinical users to ensure developments align with changing clinical requirements. Actively begin to develop collaborative relationships with commercial partners for e.g. blood pack manufacturers.

  - Year 3: Engage with industry to trial new manufacturing technologies and Pathogen Inactivation systems. Apply for research grants and funding for novel research, begin to publish research results and present WBS work at national and international conferences

Progress to Date

The component Development Laboratory has completed it's second year of operation but has already surpassed expectations, in particular it has quickly established itself as a centre of excellence in platelet research :

- Our collaboration with Cardiff Metropolitan University has supported a successful PhD student studying the importance of extracellular vesicles in cold-stored platelet concentrates. The researcher recently (April 2022) presented his work at the Biomedical Excellence for Safer Transfusion (BEST) group where it won The Scott Murphy Memorial Lectureship.
- The team in the CDR Laboratory are also following their own lines of research, in partnership with clinicians working for the Ministry of Defence, on the storage and use

of platelets and how cold storage might enhance their haemostatic capabilities in acute trauma.

- The Welsh Blood Service has also agreed to part-fund a further PhD Studentship at Cardiff Metropolitan University in this field as well as supporting a team member who is conducting research into platelet storage as part of her DClinSCi with the University of Manchester.
- We are also supporting the UK National External Quality Assurance Scheme (NEQAS) in developing a national exercise to compare platelet aggregation assays.

The CDR laboratory has also agreed to collaborate with the BEST group on a global study into the manufacturing and testing of Cryoprecipitate, and with Cardiff University on a study looking at the use of filters to remove pathogens from blood products.

Recent changes to UK guidance on the use of plasma for the manufacture of medicines such as immunoglobulins will be supported by the CDR laboratory in Wales as we work with manufacturers to develop and optimise safe systems and processes for the collection of donated plasma. This program of work will mitigate the impact on UK patients of the growth in demand for these medicines globally which is constrained by the availability of donated plasma.

Forthcoming changes to legislation governing the use of plasticiser in medical devices will have a potentially significant impact on red cell storage, and the CDR team will play a key role alongside the other UK Blood services in validating new materials for blood packs and optimising the processing and storage of red cells as a result.