

- 1.0.0 10:00 - STANDARD BUSINESS
 - Led by Prof Donna Mead (Chair)*
- 1.1.0 APOLOGIES
 - Led by Prof Donna Mead (Chair)*
- 1.2.0 IN ATTENDANCE
 - Led by Prof Donna Mead (Chair)*
 - Anna Burgess, Deputy SACT Lead Nurse - Observing*
 - David Cogan, Patient Representative*
- 1.3.0 DECLARATIONS OF INTEREST
 - Led by Prof Donna Mead (Chair)*
- 1.4.0 MATTERS ARISING
 - 1.4.1 Action Log
 - Led by Prof Donna Mead (Chair)*
 - 1.4.1 Action Log updated from 24 09 2020.docx
- 2.0.0 10:05 - CONSENT ITEMS
 - Led by Prof Donna Mead (Chair)*
- 2.1.0 FOR APPROVAL
 - 2.1.1 Minutes from the Public Trust Board meeting held on the 24th September 2020
 - Led by Prof Donna Mead (Chair)*
 - 2.1.1 Draft Minutes Public Trust Board September.docx v2 (002).docx
 - 2.1.2 Contract Acceptance & Expected Urgent Decisions over £100,000 (Procurement)
 - Led by Mark Osland, Director of Finance*
 - TB Proc Submission Summary Nov 20 v5 doc x.pdf
 - App 1 Brainlab exactrac system service agreement - Radiosurgery.pdf
 - App 2 VCC Contract for the Provision of Oncotype Testing v2.pdf
 - App 3 TCS Professional Advisors 2020-21 FINAL v3.pdf
 - App 4 NWIS Infastructure Hardware -Server Storage v2.pdf
 - App 5 NWIS P652 End User Hardware.V.01.pdf
 - App 6 NWSSP Logistics Software.pdf
 - App 7 NWSSP PRIMARY CARE STRATEGIC PLANNING PREMISES v3docx.pdf
 - App 8 NWSSP Cohort Occupational Health ESR v3.pdf
 - App 9 - Bobarth -stl- nov16-20 (003) (003).pdf
 - App 10 NWSSP GP & Primary Care Temp Workforce Engag Portal v1.1_.pdf
 - App 11 NWSSP ALL WALES ALLOCATE E-ROSTERING CONTRACT v1.1 .pdf
 - 2.1.3 Chairs Urgent Action Endorsements
 - Led by Prof Donna Mead (Chair)*
 - 2.1.3 Chairs Urgent Action Report November 2020.docx
 - 2.1.4 Approved Policies Update
 - To be led by Lauren Fear, Director of Corporate Governance*
 - 2.1.4 Policies for Approval Cover Report.docx
 - 2.1.4a App 1 NHS All Wales Lease Car Pool Vehicle Policy & Procedure September 20.docx
 - 2.1.5 Amendment to Standing Orders
 - To be led by Lauren Fear, Director of Corporate Governance*
 - 2.1.5 Amendment to Standing Orders Cover Paper_November 2020 Trust Board.docx
 - 2.1.5a GC02b MSOSchedule 3 Board Committees ToR Opt Arr.docx
 - 2.2.0 FOR NOTING

- 2.2.1 Health Inspectorate Wales (HIW) Annual Report
To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Sciences.
Annual Report for 2019 – 2020. At time of writing, health and care services across Wales have had to rise to meet the challenges of a global pandemic, Covid-19. This has introduced unique and unprecedented pressures on the system that will continue through the winter months. Services have adapted, changed and expanded to cope with these pressures and the response across Wales has to be commended.
This report covers the period 1 April 2019 to 31 March 2020 meaning that restrictions on our work due to the pandemic only affected a small proportion of our routine inspection programme and the majority of our work was completed as planned.
(Velindre University NHS Trust - see page 60)
- 2.2.2 WHSCC Joint Committee Briefings
Led by Lauren Fear, Director of Corporate Governance
The Welsh Health Specialised Services Committee held its latest public meeting on 13 October 2020 with a 'consent agenda', as described on the WHSSC website. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.
[2.2.2 WHSSC Joint Committee Briefing v1.0.pdf](#)
- 2.2.3 Governance Arrangements During Covid Update: Final Reports Following Audit Wales and Internal Audit Advisory Joint Review
To be led by Lauren Fear, Director of Corporate Governance
[2.2.3 FINAL REPORTS FOLLOWING AUDIT WALES AND INTERNAL AUDIT ADVISOR.docx](#)
[2.2.3a 1963A2020-21_VUNHST_Structured_Assessment_Final_Eng.pdf](#)
[2.2.3b VT2021-17 Covid Governance Revised Final Advisory Report Final 210920.pdf](#)
- 2.2.4 Health & Safety 2019/20 Annual Report
Led by Carl James, Director of Strategic Transformation Planning & Digital
[2.2.4 H&S Annual Report 19-20 for Q + S Committee Nov 20 docx.docx](#)
- 2.2.5 Quarter 3 and Quarter 4 Operating Plan - Progress Update
Led by Cath O'Brien, Chief Operating Officer
*\!*Progress report against Quarter 2 Delivery Plan was received at the September Board and the next update will be received at the January Board*
[2.2.5 TB 26 November - Quarter 3 - Quarter 4 Operating Plan.docx](#)
- 3.0.0 10:10 - Presentation: Delivery of Convalescent Plasma Programme - Welsh Blood Service
Led by Alan Prosser, Interim Director of WBS
- 4.0.0 KEY REPORTS
- 4.1.0 10:30 - Chairs Update
Led by Prof Donna Mead (Chair)
[4.1.0 Chair report November 2020.docx](#)
- 4.2.0 10:35 - CEO Update*
Mr Steve Ham, Chief Executive Officer
- 4.2.1 Velindre University NHS Trust still within 'routine' monitoring arrangements on the escalation framework*
Mr Steve Ham, Chief Executive Officer
- 5.0.0 QUALITY, SAFETY AND PERFORMANCE
- 5.1.0 10:40 - Quality, Safety and Performance Highlight Report
To be led by Nicola Williams, Executive Director of Nursing, AHPs and Health Scientists
[5.1 Quality, Safety & Performance Committee Highlight Report_12.11.2020.docx](#)
[5.1a App 1 Quality, Safety & Performance Terms of Reference.docx](#)
- 5.2.0 10:45 - COVID Update
Led by Cath O'Brien, Chief Operating Officer
[5.2.0 Final Board Committee - COVID Update for 26.11.20.docx v2.docx](#)
[5.2a Covid Update Appendix 1.docx](#)
[5.2b Covid Update Appendix 2.docx](#)
- 5.3.0 10:55 - Velindre University Trust Risk Update*
To be led by Lauren Fear, Director of Corporate Governance
- 5.3.1 11:00 - Trust Assurance Framework

Led by Lauren Fear, Director of Corporate Governance

5.3.1 Trust Assurance Framework - TB.docx

5.3.2 EU Exit and EU Transition

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

5.3.2 VUNHST Trust Board_EU Transition Highlight Report - 20.11.2020.docxAP.docx

5.3.2a 14860 TRR_EU Exit 18.11.20.docx

5.4.0 11:05 - Remuneration Committee Highlight Report

Led by Prof Donna Mead (Chair)

5.4.0 Remuneration Committee Highlight Report - 22.10.2020.docx

5.5.0 11:10 - BREAK

5.6.0 11:20 - Delivering Excellence Performance Report

Led by Cath O'Brien, Chief Operating Officer

5.6.0 Trust Board QSP Ctee PMF Briefing version 005_.docx

5.6.0a VCC Divisional Report. 3 nov COBs changes.docx

5.6.0b Trust-wide Performance Report - September 2020 (004).docx

5.6.0b Additional Absence Data - Board 26th Nov 20.pptx

5.6.0c WBS Divisional Report Sept 0305111 (003).docx

6.0.0 STRATEGIC DEVELOPMENT

6.1.0 11:35 - Strategic Development Committee Highlight Report

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

6.1.0 Strategic Development Committee Highlight Report Final - November.docx

6.2.0 11:40 - Transforming Cancer Services Scrutiny Sub-Committee Highlight Report

Led by Mr Stephen Harries, Vice-Chair Velindre University NHS Trust

6.2.0 PUBLIC TCS Programme Scrutiny Committee Highlight Report for Trust Board November 2020 v2CJ.docx

6.3.0 11:45 - TCS Programme Communication & Engagement Update

Led by Lauren Fear, Director of Corporate Governance

6.3.0 November 2020 TCS programme and Trust board paper_.docx

6.4.0 11:55 - Academic Partnership Board Highlight Report

Led by the Chair, Prof Donna Mead

6.4.0 Highlight Report for the Academic Partnership Board 14-10-20 V3.docx

7.0.0 INTEGRATED GOVERNANCE

7.1.0 12:00 - Financial Report Period

Led by Mark Osland, Director of Finance

7.1.0 20-21 Month 6 Finance Report Cover Paper.docx

7.1.0 M6 VELINDRE NHS TRUST FINANCIAL POSITION TO SEPTEMBER 2020 - Q, S and P Committee.docx

7.2.0 12:10 - Audit Committee Highlight Report

Led by Martin Veale, Independent Member and Chair of Audit Committee

7.2.0 Audit Committee Highlight Report 8 October 2020 part a final.docx

7.3.0 12:15 - Charitable Funds Committee Highlight Report

Led by Prof Donna Mead, Chair

7.3.0 Charitable Funds Committee Highlight Report from the 04.11.2020_. v2 DM_MOdocx.docx

7.4.0 12:20 - NWSSP Audit Committee Highlight Report

Led by Martin Veale, Independent Member and Chair of Audit Committee

7.4.0 VUNHST Audit Committee Assurance Report.docx

8.0.0 ANY OTHER BUSINESS

Prior Approval By the Chairman Required

9.0.0 DATE AND TIME OF THE NEXT MEETING

Thursday 28th January 2021

10.0.0 CLOSE

The Board is asked to adopt the following resolution:

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

VELINDRE NHS TRUST

UPDATE OF ACTION POINTS FROM PUBLIC TRUST BOARD MEETINGS UPDATED 4th SEPTEMBER 2020

MINUTE NUMBER	ACTION	STATUS	LEAD	DUE DATE/ STATUS
19.12.2019 – Extraordinary Public Trust Board				
2.0	Urgent Decisions Over £100k 1. Mr Mark Osland and Mrs Lauren Fear will be addressing the process supporting the “Over 100k Commitments” with Procurement colleagues in January 2020, and this will include a review of the detail captured within the reports as well as improving consistency of content. An update will be received at the January Trust Board meeting.	UPDATE NOVEMBER 2020 A new policy and procedure that includes a holistic review of the process, responsibilities, business case requirements and decision-making framework will undergo Trust-wide engagement and consultation through December.	MO/LF	OPEN December 2020
30.04.2020 Public Trust Board				
	1. Mr Steve Ham confirmed that he has informed the NHS CEO in Welsh Government on the status and will follow this up in writing – confirmation that the letter has been sent.	CLOSED NOVEMBER 2020 Mr Steve Ham, CEO, confirmed that funding discussions had taken place which had mitigated the requirement for a ‘Letter of accountability’	SH	CLOSED
24.09.2020 Public Trust Board				

5.1.0	Velindre University NHS Trust Committee Structure Development <ul style="list-style-type: none"> The Board was supportive of the idea and will work through the final details for the Terms of Reference and Cycle of Business. 	CLOSED – ON THE NOVEMBER AGENDA	LF	CLOSED
6.1.0	Delivering Excellence Performance Report <ul style="list-style-type: none"> The Chair requested an update on the wellbeing space staff and the Board would like be reassured on this matter. Mr Gareth Jones would like some analysis with regards to the sickness to understand the root causes of the sickness Mr Martin Veal asked about the impact of COVID and made a request to collect data on sickness and separating data on shielding or nuance staff sickness reasons. 	CLOSED – INCLUDED IN THE DELIVERING EXCELLENCE REPORTS	COB SfM SfM	CLOSED
6.2.0	Progress Report: Quarter 3/4 Plans (including Winter Plans) <ul style="list-style-type: none"> Mr Stephen Allen requested that the plans are shared with CHC before the submission and will include Aneurin Bevan, Cardiff & Vale and Cwm Taf Morgannwg 	COMPLETED	CJ	COMPLETED

MINUTES OF THE PUBLIC TRUST BOARD – PART A

VELINDRE UNIVERSITY NHS TRUST HQ/TEAMS/LIVE STREAMED THURSDAY 24TH SEPTEMBER 2020 @ 10:00

PRESENT:

Professor Donna Mead	Chair (Chair)
Mr Stephen Harries	Interim Vice Chair
Ms Janet Pickles	Independent Member
Mr Martin Veale	Independent Member
Mrs Hilary Jones	Independent Member
Mr Gareth Jones	Independent Member
Professor Donald Fraser	Independent Member
Mr Steve Ham	Chief Executive
Dr Jacinta Abraham	Executive Medical Director
Mrs Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Scientists
Mrs Sarah Morley	Executive Director of Workforce and OD

IN ATTENDANCE:

Mrs Lauren Fear	Interim Director of Corporate Governance
Mr Stephen Allen	Community Health Council (CHC) Representative
Mr Carl James	Director of Transformation, Planning & Digital
Ms Cath O'Brien	Interim Chief Operating Officer
Mrs Katrina Febry	Relationships Manager, Audit Wales
Mr Matthew Bunce	Deputy Director of Finance
Mrs Rebecca Goode	Secretariat

1.0.0	STANDARD BUSINESS Led by Professor Donna Mead (Chair) Professor Donna Mead welcomed everyone to the Trust Board Meeting being live streamed to the public on 24 th September 2020.	
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1.1.0	APOLOGIES Led by Professor Donna Mead (Chair) Apologies were received from Mr Mark Osland, Executive Director of Finance.	
1.2.0	IN ATTENDANCE Led by Professor Donna Mead (Chair) Welcome to:- <ul style="list-style-type: none"> • Ms Bernadette Rowlands - Aneurin Bevan Community Health Council Member • Mr David Cogan – VCC Patient Representative 	
1.3.0	DECLARATIONS OF INTEREST Led by Professor Donna Mead (Chair) No declarations of interest were declared.	
1.4.0	MATTERS ARISING	
1.4.1	Action Log Led by Professor Donna Mead (Chair) The action log was reviewed and updated. The Board DISCUSSED and UPDATED the action log.	
2.0.0	CONSENT ITEMS Led by Professor Donna Mead (Chair) The consent part of the agenda considers routine committee business as a single agenda item. Note: Members may ask for items to be moved to the main agenda if a fuller discussion is required.	
2.1.0	FOR APPROVAL Led by Professor Donna Mead (Chair)	
2.1.1	Minutes from the Public Trust Board meeting held on the 24th September 2020 Led by Professor Donna Mead (Chair) Minutes were APPROVED under consent.	
2.1.2	Contract Acceptance & Expected Urgent Decisions over £100,000 (Procurement) Led by Mr Mark Osland, Executive Director of Finance The Board AUTHORISED the Chair and Chief Executive to APPROVE the award of contracts summarised within this paper (and detailed within the attached Board Decision Pro-forma) and AUTHORISED the Chief Executive to APPROVED requisitions for expenditure under the named agreement.	

2.1.3	Chairs Urgent Action Endorsements Led by Mrs Lauren Fear, Interim Director of Governance The Board APPROVED the Chairs urgent action taken since the September 2020 Trust Board Meeting.	
2.1.4	NWSSP Delegated Authority Extension Led by Mark Osland, Director of Finance The Board APPROVED a further extension to the financial scheme of delegation in respect of COVID 19 related contracts allowing the Chair and either the Managing Director or the Director of Finance and Corporate Services of NWSSP to continue to approve contracts up to £5m, until 31 March 2021	
2.1.5	Trust Seal Report Led by Prof Donna Mead (Chair) APPROVED under consent.	
2.1.6	Approved Policies Update Led by Lauren Fear, Interim Director of Corporate Governance APPROVED under consent.	
2.1.7	Welsh Language Annual Report Executive Director of OD & Workforce APPROVED under consent.	
2.1.8	NWIS Wales Informatics Service (NWIS) - Velindre Exit Led by Mark Osland, Director of Finance Mr Martin Veale confirmed, to the Board, that the NWIS exit plan had been discussed through the Audit Committee and updates will be included in the next Audit Highlight Report. APPROVED under consent.	
2.1.9	Annual Quality Statement (AQS) Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists APPROVED under consent.	
2.2.0	FOR NOTING	
2.2.1	Collaboration Leadership Forum Minutes	

	<p>Led by Lauren Fear, Interim Director of Corporate Governance</p> <p>Following the meeting of the Collaborative Leadership Forum held on 28 July, the Board received the final minutes of the meeting held on 15 January. These are for reporting to all Health Boards and Trusts, as part of the Collaborative's agreed governance arrangements.</p> <p>NOTED under consent.</p>	
2.2.2	<p>Workforce Planning Guidance</p> <p>Led by Sarah Morley, Executive Director of OD & Workforce</p> <p>NOTED under consent.</p>	
2.2.3	<p>Advanced Therapies (Cell & Gene) status update: Advanced Therapies Wales / Midland -Wales Advanced Therapies Treatment Centre Precision Medicine Service</p> <p>Led by Cath O'Brien, Interim Chief Operating Officer</p> <p>NOTED under consent.</p>	
2.2.4	<p>Convalescent Plasma Highlight Report</p> <p>Led by Cath O'Brien, Interim Chief Operating Officer</p> <p>NOTED under consent.</p>	
3.0.0	KEY REPORTS	
3.1.0	<p>Chairs Update</p> <p>Led by Professor Donna Mead (Chair)</p> <p>The Chair updated the Board and confirmed that the report was for noting and highlighted the following items:</p> <ul style="list-style-type: none"> • The Chair announced Lauren Fear as the permanent Director of Corporate Governance. • A summary of the planning for radiotherapy capacity modelling, the planning process for the new Velindre Cancer Centre and the regional cancer service model were discussed at the 27th August Board Development session. • A summary of the 10th September Board Development session was given which discussed the systematic anti-cancer therapy (SACT), risk strategy work and engagement plan for the regional cancer service model. • Update on the new committee structure, risk appetite and board champion roles. • The Chair invited nominations for the Queen's Birthday Honours 2021. • The Minister for Health and Social Services confirmed a 1 year extension for Mrs Jan Pickle's appointment. 	

	<ul style="list-style-type: none"> Upcoming events:- <ul style="list-style-type: none"> Integrated Governance Group meeting on the 21st September Annual General Meeting (AGM) is scheduled for the 22nd October <p>The Board NOTED the report.</p>	
3.2.0	<p>CEO Update Led by Mr Steve Ham, CEO</p> <p>Mr Steve Ham summarised the report and highlighted the following:</p> <ul style="list-style-type: none"> The development of the clinical model and Nuffield appointed to provide independent advice. Considerations of service delivery over the next period with regards to the performance and the next phase of the pandemic. An update on preparing for the next phase as an organisation with regards to the new committee structure and the Risk & Assurance strategy. <p>Mr Stephen Allen, Community Health Council, requested that the patients are kept informed about how they access the services going forward.</p> <p>The CEO confirmed this was more about the management arrangements and to assure the Board that the Trust is committed to keeping the patients informed on the developments. This was really a conversation regarding management arrangements</p> <p>The Board NOTED the report.</p>	
4.0.0	QUALITY & SAFETY	
4.1.0	<p>Quality and Safety Highlight Report Led by Ms Janet Pickles, Chair of the Quality & Safety Committee</p> <p>Mrs Janet Pickles highlighted that since March 2020 the Quality & Safety Committee had been held monthly, in response to COVID-19, and has expanded the remit to accommodate the workforce agenda. There were no current issues to alert to the Board.</p> <p>Mrs Pickles informed the Board of the innovative work with Welsh Blood Service (WBS), particularly on the donations from patients' with haemochromatosis which puts a different lens on the condition. This highlights an opportunity to build on the wellbeing of those people with that condition.</p> <p>Mrs Pickles said that the Quality & Safety reports were improving and showing how the Trust is becoming a learning organisation and bolstered by the Shared Listening and Learning Highlight report.</p> <p>The Annual Quality Report was also appended to the highlight report for information.</p>	

	<p>Finally the Board were informed of two vaccination programmes, Flu and COVID19 and will be working through the logistics of delivering these through the next few weeks and will keep the Board fully apprised with the progress. The Board NOTED the update from the Quality & Safety Committee.</p>	
4.2.0	<p>Development of Velindre University Risk Strategy, Appetite and Assurance Framework</p> <p>Led by Lauren Fear, Interim Director of Corporate Governance</p> <p>Mrs Lauren Fear summarised the report and explained how, in January 2020, the Trust began this ambitious schedule to implement the Risk strategy and Framework. The Board were asked to approve the next steps and the templates that support the framework as listed in the report.</p> <p>The Board were informed that the Trust had undertaken 18 workshops across all functions to develop the content and it would be brought together for endorsement by Audit Committee.</p> <p>The Chair thanked Mrs Fear and confirmed that it has been a full process that had been done very well and to convey the Board's thanks to the team.</p> <p>Mr Martin Veale welcomed the Risk strategy and supporting guidance for the Trust.</p> <p>Mr Steve Ham confirmed that this was a big development for the Trust and embedding the framework will be key both culturally and the implementation of the process will test the process.</p> <p>The Board APPROVED:</p> <ul style="list-style-type: none"> • Risk Management Framework – Appendix 1 • Risk Management Process – Appendix 2 • Risk Appetite Strategy – Appendix 3 • Updated Risk Appetite levels set by the Board – as set out in the Risk Appetite Strategy • Trust Assurance Framework – Appendix 4 <p>The Board NOTED the on-going development of the risk and assurance control frameworks and SUPPORTED the next steps as articulated in this paper</p>	
5.0.0	INTEGRATED GOVERNANCE	
5.1.0	<p>Velindre University Committee Structure Development</p> <p>Led by Lauren Fear, Interim Director of Corporate Governance</p> <p>Mrs Lauren Fear introduced the new Committee Structure Development as set out in the report and appendices.</p>	

	<p>The Chair thanked Mrs Fear and the Team for the work involved in bringing these committees together. The development of the Quality & Safety data that was referenced earlier in the meeting was already demonstrating triangulation of the data such as workforce, quality and safety together. Also to note the emphasis to drive strategy going forward with the Strategic Development Committee.</p> <p>Mrs Fear acknowledged the huge team effort on this project and thanks to Mrs Rebecca Goode and Ms Emma Stephens on bringing this process together and the supporting documents received at the Board today, 24th September 2020.</p> <p>The Board were asked to approve the Committee Structure, the Terms of Reference and cycle of business which will be endorsed and approved through the inaugural committees as the next step. The final Terms of Reference and cycle of business will then be brought to the November Board as a complete set of papers.</p> <p>Mrs Fear referenced page 6 of the report, which lists all of the meetings and processes that has brought all of this committee work together.</p> <p>Mr Steve Ham welcomed this development and the change in the way of working that goes beyond structures.</p> <p>Some comments/notes:-</p> <ul style="list-style-type: none"> • Mr Martin Veale – said the diagram will need to show the NWSSP Shared Audit Committee – this will need to be included in the structure. • Ms Sarah Morley – welcomed the development for the WF&OD agenda and how it will work across every aspect of the organisation and very pleased with this new structure. • Dr Jacinta Abraham – used the opportunity to announce the new Associate Medical Directors (AMD) and this structure will support this process going forward. It is a welcome change for the Trust. Dr Abraham said thank you to all of the Board for their support with the AMDs and supporting their inductions. To confirm that there will be 5 AMDs who have been appointed and will share further information with you all in due course. • The Chair, Prof Donna Mead, said it is important to the new structure and how the newly appointed Associate Medical Directors feed into the process will be key to the leadership process. • Mr David Cogan informed the Board that charitable funds has a recognised patient representative and asked if there had been consideration for the other committees? The Chair confirmed that the membership of the two committees was still under review but would welcome patients' involvement. <p>The Board took a 'show of hands' and were supportive of the new Committee Structure.</p>	<p>COMPLETED 27 09 2020</p>
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	<p>Actions:</p> <ul style="list-style-type: none"> The Board was supportive of the idea and will work through the final details for the Terms of Reference and Cycle of Business. <p>The Board APPROVED the new Committee structure.</p> <p>The Board NOTED the draft new and updated Terms of Reference and Cycles of Business to support the new Committee Structure. The Board SUPPORTED these documents to be finalised through the inaugural meetings of each of the Committees and Sub-Committees under this new structure, prior to being brought back to Board for approval. These changes will then also be reflected in the Trust's Standing Orders.</p>	
5.2.0	<p>Local Partnership Forum Highlight Report</p> <p>Led by Sarah Morley, Executive Director of OD & Workforce</p> <p>Ms Sarah Morley confirmed that during the first phase of the pandemic the Trust met regularly with Trade Unions and are continuing to work in partnership through the regular meetings.</p> <p>The Chair and the Board were pleased to note the work with the Trade Unions and welcome future updates at Board.</p> <p>The Trust Board NOTED the update.</p>	
6.0.0	PLANNING & PERFORMANCE:	
6.1.0	<p>Delivering Excellence Performance Report</p> <p>Led by Cath O'Brien, Chief Operating Officer</p> <p>Mrs Cath O'Brien set the context for the paper and firstly acknowledged the work with David Cogan and the discussions about ways of engaging with patients in service development.</p> <p>The report covers the following:-</p> <p><u>Velindre Cancer Centre (VCC)</u></p> <ul style="list-style-type: none"> Capacity and how we keep staff and patients safe. With regards to radiotherapy (RT) and systematic anti-cancer therapy (SACT) to give assurance that we have maintained word missing and working within a robust framework. Mrs O'Brien confirmed that there have been no patients that have breached the waiting times for treatment. The Cancer Centre is starting to return services back to the Health Boards (HBs) and agree on a regional basis how we move forward with what will be a difficult time. 	

- Unscheduled care will have project updates from the Task & Finish group and will share with the Board and will feed through the Quality, Safety & Performance Committee.
- Prof Donald Fraser asked if there are any measures for the unscheduled care and any details on key breaches. Mrs O'Brien confirmed that there are two parts which the data will need to separate. The existing quality system that reports on acutely unwell patients. The Group is looking at pathways which can be improved and confirmed that there are general themes but not aware of any specific issues. Breaches of SACT and RT are routinely monitored. The Trust do not have metrics for unscheduled care. The Velindre Cancer Centre (VCC) do have a robust admission policy to ensure that each patient is reviewed in the assessment unit and it has a clear process for checking on how best to care for those patients. The other metrics, like thrombosis and septic metrics are also monitored.
- Emergency SACT table on page 2 – the escalation process is an assessment process that includes priorities on clinical need. That is led by Dr Eve Gallop-Evans. The table shows the two patients (what that breached or weren't escalated), acknowledging there was a failing there and a root analysis has been undertaken and lessons learnt.

Welsh Blood Service (WBS):

- Stem Cell – we have had a number of cancellations but this has been assessed and there are no variations in trends. Also freezing is in place for transportation.
- Efficient metrics is not where it should be. This is being worked on and whilst managing to maintain the service. There are Difficulties with finding blood donation venues and working within social distancing and infection control conditions. The Board were informed that WBS are working with Public Health Wales (PHW) to support the messaging to ensure that WBS maintain blood stock and wider the services.
- Mrs O'Brien was keen to thank all of the venues for supporting WBS and to thank PHW for supporting the 'Donor' message.
- Mr Martin Veale noted the list is very much changed and it is very encouraging to see places available to donate Blood.
- The HBs were supportive of the approach and working within a cohesive plan to maintain service levels.
- PADRs, wellbeing of staff and sickness levels remain relatively unchanged.
- Ms Sarah Morley was keen to note that the role of the PADRs should focus on the well-being of staff and to make sure that the focus remains on supporting staff.
- Mrs O'Brien confirmed that the progress on the well-being space in VCC had not progressed as quickly as she would have liked and that further options are being considered.
- Ms Morley confirmed that there was more focus on the Employee Assistance Programme to support the mental wellbeing of staff and there were plans to communicate with

	<p>staff and family. Also highlighted the support for managers to obtain advice to support the staff.</p> <p>The Chair noted it is the 6th year without MRSA occurrence and the incidence of infection is very low. The Board would like to pass on their thanks to the Team for this outstanding achievement.</p> <p>Actions:</p> <ul style="list-style-type: none"> • The Chair requested an update on the wellbeing space for staff and the Board would like be reassured on this matter. • Mr Gareth Jones would like some analysis with regards to the sickness to understand the root causes of the sickness • Mr Martin Veal asked about the impact of COVID and made a request to collect data on sickness and separating data on shielding or nuance staff sickness reasons. <p>The Board NOTED the update</p>	<p>COB</p> <p>SfM</p> <p>SfM</p>
6.2.0	<p>Progress Report: Quarter 3/4 Plans (including Winter Plans) Led by Cath O'Brien, Chief Operating Officer</p> <p>Mr Carl James outlined the Quarter 1/2 plans to address the very immediate issues for the services which also begins to set out the process for Quarter 3/4 until the end of the financial year.</p> <p>Mr James confirmed that the intention was to bring the draft plan to the Trust Board today but Welsh Governance (WG) were still providing templates and winter planning guidance and confirmed the revised deadline of October 21st to submit the plans.</p> <p>The Board were assured of the excellent forecasting work going on with WBS and the work with the HBs on cancer planning. The Trust is now required to go through the anticipated scenarios and the planning approaches.</p> <p>Mr James confirmed the next steps are to populate the plans and take it through the Board for final consideration at the Board Development session in October and then for formal approval in November.</p> <p>Action:</p> <ul style="list-style-type: none"> • Mr Stephen Allen requested that the plans are shared with CHC before the submission and will include Aneurin Bevan, Cardiff & Vale and Cwm Taf Morgannwg <p>The Board NOTED the contents of the progress reports.</p>	<p>CJ</p>
6.3.0	<p>Progress Report against Quarter 2 Plans Led by Cath O'Brien, Chief Operating Officer</p>	

	<p>Mrs Cath O'Brien briefly updated the Board and confirmed the work will continue through until the end of the year and some will be reviewed as we move through the next few years.</p> <p>The Chair confirmed that she was pleased to see the progress with the outreach departments</p> <p>The Board NOTED the reports.</p>	
6.4.0	<p>Project Review - Well-being of Future Generations (Wales) Act (2015) & Blood Supply Chain 2020</p> <p>Led by Cath O'Brien, Interim Chief Operating Officer</p> <p>The Chair thanked Mrs Cath O'Brien for the update and asked for an understanding of how this work began. The work started with a group of staff enthusiastic about the Future Generations & Wellbeing Act who undertook an exercise to look at the whole blood supply chain. They wanted to demonstrate how WBS live by the Act and to show the achievements that WBS were making. Mrs O'Brien acknowledged the work of Ms Rhiannon Collins and Mrs Sarah Richards which captures the full WBS Supply Chain.</p> <p>Mrs O'Brien confirmed that much of this work was being done and it was important to capture the initiatives to ensure that WBS and the wider Trust captures the work with the community.</p> <p>The Board NOTED the update and asked to relay their thanks the relevant staff and how pleased the Board were to receive the paper.</p>	
6.5.0	<p>Financial Report</p> <p>Led by Mark Osland, Director of Finance</p> <p>Mr Matthew Bunce briefly summarised the financial position as outlined the report and confirmed the key risk was the reimbursement of the COVID expenditure.</p> <p>Mr Gareth Jones enquired when WG confirm the TCS capital funding and if using the discretionary funding will impact the Organisation's plans. Mr Carl James confirmed that the capital finance decision was with the Minister and hoping for some feedback today 24th September 2020. Also, Mr James reassured the Board that there was nothing being delayed due to impact on using discretionary funds.</p> <p>The Board NOTED the update and the end of year position was based on the COVID expenditure as being reimbursed.</p>	
6.6.0	<p>TCS Programme Committee Update</p> <p>Led by the Stephen Harries, Vice-Chair and Chair of the TCS Scrutiny Committee</p> <p>Mr Stephen Harries confirmed that the last meeting was on the 17th September 2020 and therefore an oral update for Trust Board.</p>	

	<p>The items for discussion:-</p> <ul style="list-style-type: none"> • To confirm the Trust is waiting on the capital funding for progressing the TCS programme, projects 1 and 2. • Reformatting of risk and templates • The Committee received an update on communications and engagement for the project <p>The highlight report will be shared at the next Trust Board.</p> <p>Trust Board are asked to NOTED the oral update</p>	
6.7.0	<p>TCS Programme Communication & Engagement Update Led by Lauren Fear, Interim Director of Corporate Governance</p> <p>The Chair confirmed that she was pleased to see this item on the agenda and would welcome Q&As after the discussion.</p> <p>Mrs Lauren Fear confirmed the plan as follows:-</p> <ul style="list-style-type: none"> • Delivering on the social media plan and thanked David Cogan's post from the patient's perspective • Reference of the programme of work with engagement of all stakeholders • Noting the response to petitions that were heard by the Petitions Committee in the Senedd and awaiting the formal response from the committee. <p>Mr Stephen Harries informed the Board of the staff engagement sessions which involved listening to concerns from staff. Interesting to obtain their insight and observations.</p> <p>Mrs Fear confirmed that there were two Facebook pages; one in support and one not in support of the current plans. The concern expressed is that the Facebook page that supports the Trust developments is endorsed by Trust. The Board would like to note:-</p> <ul style="list-style-type: none"> • that both Facebook pages are independent of the Trust • The VCC Facebook page and how we use it is under review as concern has been raised from patients who are in their cancer journey and for some patients the content of the various facebook pages do not sit comfortably together. <p>The Chair is keen to ensure that there is a balanced discussion and view on this. The Chair reinforced that the Trust do not provide any support to the supporters Facebook.</p> <p>Mr Carl James suggested that the plans for social media are taken forward outside of the meeting. The Board agreed that we do have 20,000 people with an interest and how do we challenge ourselves to use that network well and to listen to all stakeholders. The Board will receive further updates in due course.</p> <p>Trust Board NOTED the update.</p>	

7.0.0	ANY OTHER BUSINESS <p>The Chair was not made aware of any other business.</p> <p>The Chair asked members if there were any observations or questions which weren't asked during the meeting. The opportunity was offered to raise them at this point. . Everyone present were content that they had been given the opportunity to express their views and provide feedback.</p>	
8.0.0	DATE AND TIME OF THE NEXT MEETING <p>Annual General Meeting 22nd October 2020 @ 2pm (Details will follow)</p> <p>Next Trust Board Meeting is the 26th November 2020.</p>	

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENTS EXCEEDING £100k FOR THE PERIOD 26th November 2020 to 27th January 2021

DATE OF MEETING	26 th November 2020
PREPARED BY	Helen James
PRESENTED BY	Mark Osland
EXECUTIVE SPONSOR	Mark Osland

REPORT PURPOSE	For approval.
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING:		
NAME OF COMMITTEE OR GROUP	DATE	OUTCOME
Numerous in accordance with the governance of the Division or Hosted Unit of the Trust.	Various.	Endorsed for submission to Trust Board.

ACRONYMS	VCC – Velindre Cancer Service, TCS – Transforming Cancer Services, NWIS - NHS Wales Informatics Service, NWSSP NHS Wales Shared Service Partnership
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1. SITUATION/BACKGROUND

1.1. The Chief Executive's financial limit is £100k; purchases/ contracts requiring approval / extending over this amount requires Trust Board approval. For extensions, this only applies if the provision for extension was not included in the original approval granted by Trust Board.

1.2. The decisions expected during the period between Trust Board meetings are highlighted in this report, seeking approval for the Chief Executive and Chair to authorise approval outside of the Trust Board.

2. ASSESSMENT

2.1 Option Appraisal / Analysis:

Prior to the submission of this paper, each requirement will have undertaken an assessment by the Division or Hosted Unit, the outcome of which is variable and represented in the tender specification.

2.2 Impact Assessment:

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Due authority is being sought in advance of expenditure to ensure compliant provision of goods/services to meet operational requirements.
RELATED HEALTHCARE STANDARD	This paper cuts across many of the Healthcare Standards, as it concerns the purchase of goods and services required to support operational needs.
EQUALITY IMPACT ASSESSMENT	Undertaken on a case-by-case basis, as part of the procurement process.
LEGAL IMPLICATIONS / IMPACT	If applicable, as identified in each case as part of the service design/ procurement process.
FINANCIAL IMPLICATIONS / IMPACT	Please see table below. Order placement subject to WG funding is indicated with a '*' against the value.

For each of the schemes seeking approval, a Board decision proforma is appended to this report. The following provides a summary of the decisions being sought from the Board

Appendix No	Division	Scheme/Contract/ Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (ex VAT)
1	VCC	Brainlab exactrac system service agreement - Radiosurgery	1 st April 2021 to 31 st March 2024 with the option to extend for a further 2 years	289,260
2	VCC	Contract for the Provision of Oncotype Testing	November 2020 to 31 st October 2022	303,750
3	TCS	TCS The provision of Professional Legal Advisory Services	1 st December 2020 to 31 st August 2023	536,283
4	NWIS	Infrastructure Hardware- Server and Storage	15 th December 2020 to 14 th December 2021 with the option to extend for a further year.	1,329,000
5	NWIS	End User Hardware for GP's, NWSSP NWIS and Other Supported Organisations	1 st April 2021 and conclude on 31 st March 2023, or 31 st March 2024 if the optional extension is utilised.	10,682,676
6	NWSSP	Logistics Software	1 st January 2021 to 31 st December 2024 with the option to extend 12 months plus 12 months	400,000

7	NWSSP	Primary Care Strategic Planning – Premises Future Look	9 th November 2020 to 30 th March 2021	280,000
8	NWSSP	Cohort Occupational Health System	1 st December 2020 to 30 th November 2021 with option to extend for 12 months.	296,202
9	VCC	Bobarth Building Lease	18th December 2020 to 17th December 2025	179,134
10	NWSSP	GP and Primary Care Temporary Workforce Engagement Portal and Reporting	19th December 2019 to 30th November 2022 with option to extend for a further 3 years in annual increments	218,400
11	NWSSP	NWSSP All Wales Allocate Rostering contract	1st December 2020 to 30 th November 2025	8,840,274

3. RECOMMENDATION

- 3.1 The Board is requested to **AUTHORISE** the Chair and Chief Executive to **APPROVE** the award of contracts summarised within this paper (and detailed within the attached Board Decision Pro-forma) and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT: *Brainlab exactrac system service agreement - Radiosurgery*

2. CONTRACT DETAILS

2.1. *Description of Goods / Services/ Works/Lease*

Service agreement for hardware for the BrainLAB exactrac system. Although similar functionality is a part of the IRS procurement, it is almost certain that the Exactrac hardware will be in use until phase 3 of the project (transfer to nVCC). Therefore a 3 years (option to extend +1 +1 years) package is deemed appropriate.

2.2. *Nature of Contract*

(Please complete either 2.2.1 or 2.2.2).

2.2.1. *New/First time contract*

Not applicable

- **Date of Board approval of business case**

Not applicable

- **Issues to bring to Board's attention that differs from the detail within the approved business case.**

Not applicable

- **Details of any matters that may be considered as Novel or contentious**

Not applicable

2.2.2. *Contract Renewal*

Renewal of existing services.

Hardware and application support package extract X-ray (System age - 5 Years)
Hardware and Application Support Package for one ExacTrac X-Ray and one ExacTrac
Infrared systems as well as the Prep&Review station,

Hardware and application support package extract X-ray (System age - 3 Years - Hardware and Application Support Package for one ExacTrac X-Ray and one ExacTrac Infrared systems as well as the Prep&Review station,

Hardware support package for Frameless SRS - Hardware Support Package for Frameless SRS hardware components,

By renewing for 3 years (Option to extend +1 +1 years) we will be aligned to the new IRS procurement program

2.3. Procurement Route

Direct award through NHS Supply Chain Framework agreement

2.4. Timescales for implementation

01/04/2021 Renewal date - no implementation period required

2.5. Period of Contract

1/4/2021 TO 31/03/2024 (Option to extend for a further 2 years until 31/03/2026)

2.6. Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).

Title	Fy21/22 £ (excl VAT)	FY22/23 £ (excl VAT)	FY23/24 £ (excl VAT)	FY24/25 £ (excl VAT)	FY25/26 £ (excl VAT)	Total £ (Inc. VAT)
Renewal	£57852	£57852	£57852	£57852	£57852	£289,260
Total						

2.7. Source of Funds

Revenue

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a ***declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.*** Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:

Service Area:

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT:

CONTRACT FOR THE PROVISION OF ONCOTYPE TESTING

2. CONTRACT DETAILS

2.1. Description of Goods / Services/ Works/Lease

This is a commissioned service by Health Boards to test patient samples to determine whether certain treatments are viable and prevents unnecessary interventions.

2.2. Nature of Contract **(Please complete either 2.2.1 or 2.2.2).**

2.2.1. New/First time contract

New contract as a Direct Award, though service has been commissioned with the same supplier for greater than 3 years

- **Date of Board approval of business case**

Not applicable

- **Issues to bring to Board's attention that differs from the detail within the approved business case.**

Not applicable

- **Details of any matters that may be considered as Novel or contentious**

Not applicable

2.2.2. Contract Renewal/Extension

New contract as a Direct Award, though service has been commissioned with the same supplier for greater than 3 years

2.3. Procurement Route

Direct Award through NHS Supply Chain Framework. In August 2020, the Cancer Network representative advised Commissioners that any alternative providers were not in a position to supply the services required and advised that the current provider was retained (2 providers, one focused on research, the other was not viable). On behalf of the commissioners, Velindre were requested to secure a 24 month contract in collaboration with Swansea Bay, on the best value for money basis. As alternative providers evolve in the ability to provide testing, the position will be reviewed.

2.4. Timescales for implementation

Immediate

2.5. Period of Contract

2 years effective 1st November 2020

2.6. Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).

Title	Fy20/21 £ (excl VAT)	FY21/22 £ (excl VAT)	FY22/23 £ (excl VAT)	Total £ (Inc. VAT)
Oncotype Testing	£63,281	£151,875	£88,594	£303,750
Total	£63,281	£151,875	£88,594	£303,750

2.7. Source of Funds

Revenue recovery of cost as a recharge to respective commissioners for costs incurred.

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a **declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with**. Procurement Services retain this confirmation electronically in the tender file.



Lead Director Name:

Service Area:

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. SCHEME TITLE

Transforming Cancer Services (TCS) Programme – New Velindre Cancer Centre Project

2. CONTRACT DETAILS

2.1. Description of Services

The provision of Professional Legal, Financial and Insurance Advisory Services Velindre is a pilot for the WG Mutual Investment Model (MIM), the conditions of operating under this model are to use the Welsh Government procured Professional Advisors Framework. The 'Transforming Cancer Services in SE Wales Programme' has compliantly utilised this framework for some time to ensure continuity and consistency of advice as befits the scale and complexity of this scheme. The Framework structure comprises of three lots enabling the appointment of a specialist firm with the requisite skillset.

The providers appointed were as follows:

- **Lot 1: Legal: DLA Piper**
- **Lot 2: Financial: PWC**
- **Lot 3: Insurance: Willis**

Due to the scope and complexity of this scheme, there has been a continuing need to call off under the terms and conditions as set in the WG framework.

However, the Welsh Government has advised the nVCC Project that this framework is to be closed by the end of the 2020 calendar year. Therefore, the nVCC Project has a need to secure those advisory services procured through this framework through a new procurement process. The Project intention is to use the appropriate procurement framework(s) to procure these services, as that would be the normal route for a public service body to take.

In order to commence the Stage 2 – post OJEU (Competitive Dialogue stage) element of the procurement process the professional advisors need to be procured.

2.2. Nature of Contract

2.2.1. **New Contract**

The Project proposes to procure the same professional advisors. The reason for continuation will support the continuity of relationship with the professional advisors; provide stability with regards understanding the detail of the nVCC Project; the professional advisors were key in the development of the WG MIM policy; they offer further advice on other advisory areas such as technical advice; and have expertise in the Competitive Dialogue procurement process. To do otherwise and appoint new provider(s) would undermine the delivery of value for money, as a new provider would have to start from the beginning of the project thus incurring duplicate charges

In respect of the performance of the professional advisors, the Project assessment is that they have provided an excellent service to date, with the required project outputs in an excellent standard and there have not been any performance related matters recorded.

The new contract(s) are required to commence the Stage 2 – post OJEU (Competitive Dialogue stage) activity as follows during the 2020-21 financial year:

DLA Piper

- | | |
|-----------------------------------|----------|
| • Pre-Qualification Questionnaire | £30,060 |
| • Dialogue Stage | £510,000 |

PwC

- | | |
|-----------------------------------|----------|
| • Pre-Qualification Questionnaire | £59,870 |
| • Dialogue Stage | £430,815 |

Willis Towers Watson

- | | |
|------------------|---------|
| • Dialogue Stage | £15,000 |
|------------------|---------|

Note: The estimated costs are based on activity schedules provided by the suppliers and include a 10% contingency.

2.3. **Procurement Route**

The following frameworks will be accessed to make direct awards following advice from Mills & Reeves Solicitors:

Framework	Lot	Supplier
CCS Framework RM3788: WPS Legal Services	2b – Full Service Firms – Scotland [for the wider public sector]	DLA Piper
CCS Framework R6020: Insurance and Related Services 3	1 – Insurance Brokerage and Associated Services	Willis Towers Watson
Shared Business Services Framework: Consult 18: Multidisciplinary Consultancy Services	6 - Finance	PwC

2.4. Timescales for implementation

The current WG framework order(s) need to be finalised by December 2020. The new order(s) will commence from January 2021.

2.5. Period of Contract

All contracts will cover the competitive dialogue process up to the summer 2023.

2.6. Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).

We have worked closely with our Professional Legal Advisers (DLA) to provide an estimate of future costs:

Title	£ (excl VAT)	£ (incl VAT)
Expenditure approved to-date	0	0
Further approval required for additional expenditure	536,283	643,540
Total	536,283	634,540

VAT recoverable elements are limited to legal professional advice or opinion as opposed to work undertaken on behalf of the Authority so may not be 100% recoverable.

We have worked closely with our Professional Financial Advisers (PwC) to provide an estimate of future costs:

Title	£ (excl VAT)	£ (incl VAT)
Expenditure approved to-date	0	0
Further approval required for additional expenditure	490,685	588,822
Total	490,685	588,822

We have worked closely with our Professional Financial Advisers (Willis Towers Watson) to provide an estimate of future costs:

Title	£ (excl VAT)	£ (incl VAT)
Expenditure approved to-date	0	0
Further approval required for additional expenditure	15,000	18,000
Total	15,000	18,000

2.7. **Source of Funds**

Welsh Government All Wales Capital Programme and is subject to approval of the nVCC OBC.

However, we have submitted a request to the Welsh Government for the necessary funding for 2020-21 to cover PQQ c£87,230.

3. **DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE**

- 3.1. The lead Director, by signing this request for Board approval, is making a ***declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.***



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth
GIG Felindre
Velindre NHS Trust

Signed:

Print Name: David Powell

Job Title: nVCC Project Director

Date: 7th September 2020

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT:

INFASTRUCTURE HARDWARE- SERVER AND STORAGE

2. CONTRACT DETAILS

2.1. Description of Goods / Services/ Works/Lease

NHS Wales Informatics Services (“NWIS”) are looking to procure additional servers and storage equipment to augment the current NWIS Estate at its datacentres to minimise the risk of to clinical services in the terms of network connectivity, maintaining reliable and retrievable services, in addition to providing a proactive and reactive infrastructure service availability and performance monitoring. A range of servers and storage devices are required; replacement backup servers, tape libraries, domain controllers are needed to update the existing estate, in addition, monitoring infrastructure, additional hosting servers, polling engines and server monitors are required to monitor, power usage, pre-failure alerts, faults and performance.

As part of the capital expenditure programme the following items are required to be procured. These will be purchased with 5- and 7-year warranties along with the pro support plus support package to ensure that this equipment is adequately supported and maintained for the duration of its serviceable life.

Item Description	Quantities		
	Core	Optional	TOTAL
R740XD server	8	4	12
ML3 Tape library	8	4	12
R440 server	54	27	81
APC EcoStruxure for up to 50 racks	1	0	1
R640 Server	6	2	8
SC Storage array	2	0	2

SolarWinds Polling Engine	1	0	1
PKI Hosting Server	1	0	1

2.2. Nature of Contract

(Please complete either 2.2.1 or 2.2.2).

2.2.1. New/First time contract

This procurement is for new server and storage hardware to facilitate additional investment into the NWIS estate.

▪ **Date of Board approval of business case**

A business case is not required for this procurement as budget has been allocated from the NWIS end of year capital budget.

▪ **Issues to bring to Board's attention that differs from the detail within the approved business case.**

Not applicable

▪ **Details of any matters that may be considered as Novel or contentious**

Not applicable

2.2.2. Contract Renewal/Extension

Not applicable

2.3. Procurement Route

A further competition will be undertaken via the National Procurement Service ("**NPS**") IT Products and Services (ii)Framework (NPS-ICT-0094-19) Lot 2 Hardware.

The WG notification process for awarding competitions exceeding £1m is not required for this project as this was a further competition via the NPS Framework.

2.4. Timescales for implementation

It is anticipated that the procurement process will be completed by the end of December 2020. Following contract award, the successful supplier will be required to have delivered all initial goods following receipt of the purchase order by the 31st March 2020.

2.5. Period of Contract

One year from 15th December 2020-14th December 2021 with the option to extend for a further year.

2.6. Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).

Title	FY20/21 £ (excl VAT)	Total £ (Inc. VAT)
Core Requirements	£886,000.00	£1,063,200.00
Optional Requirements	£443,000.00	£531,600.00
Total	£1,329,000.00	£1,594,800.00

2.7. Source of Funds

The funding is being provided from the NWIS end of year capital budget; this funding is required to be spent by 31st March 2021.

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a **declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with**. Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:

Service Area:

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT:

END USER HARDWARE FOR GP'S, NWSSP, NWIS AND OTHER SUPPORTED ORGANISATIONS

2. CONTRACT DETAILS

2.1. Description of Goods / Services

The NHS Wales Informatics Service (NWIS) provides a service to GPs, NWSSP, NWIS and other supported organisations, to manage elements of their IT estate i.e. desk top computers. The requirements for the renewal of this contract are as listed in the Table 2A. NWIS also require costings for 'added value services' [Table 2B] on a per device basis.

All purchases made by NWIS are reliant on the confirmed funding from the organisation requesting the End User Hardware.

As the contract is for up to three years the contract will allow for an annual technology refresh with the ability to agree the make, model and pricing for the following twelve (12) month period in line with the specification requirements in the tender.

The following tables provide a high-level summary of the requirements:

Item No	Item Description	Total
A1	Desktop PC – Standard Spec Small Form Factor	7950
A2	Desktop PC (WDS) - Micro Desktop	600
A3	Laptop – Standard Spec 13.3 inch	1625
A4	Laptop – High Spec 13.3 inch	1625
A5	Laptop – High Spec 14 inch	1625
A6	Laptop – Standard Spec 14 inch	1625
A7	Standard Dock	6500
A8	Monitor 22"	4325
A9	Monitor 24"	4325
A10	Laptop rucksack	1000
A11	Mouse	1000

Table 2B	
Item Description	
B1	<p>Added Value Services:</p> <ul style="list-style-type: none"> • Asset Recovery Service with the ability to collect and securely decommission hardware from multiple end user locations • Windows Autopilot, a new Windows 10 feature which helps customers enable automatic Windows device configuration out of the box • Software to assist with the manageability, compliance and security of endpoints

2.2. **Nature of Contract**

(Please complete either 2.2.1 or 2.2.2).

2.2.1. **New/First time contract**

Not applicable

▪ **Date of Board approval of business case**

Not applicable

▪ **Issues to bring to Board's attention that differs from the detail within the approved business case.**

Not applicable

▪ **Details of any matters that may be considered as Novel or contentious**

Not applicable

2.2.2. **Contract Renewal/Extension**

Renewal of the existing contract for End User Hardware that expires on the 31st March 2021.

2.3 **Procurement Route**

A further competition will be undertaken via the National Procurement Service ("**NPS**") IT Products and Services (ii)Framework (NPS-ICT-0094-19) Lot 2 Hardware.

The Welsh Government notification process for awarding competitions exceeding £1m is not required for this project as this is a further competition via the National Procurement Service (NPS) Framework.

2.4 Timescales for implementation

It is anticipated that the procurement process will be completed by the end of December 2020. Following contract award, the successful supplier will be required to have delivered all goods following receipt of the purchase order within 10 days during the term of the contract.

2.5 Period of Contract

The contract term will be for two (2) years plus the option to extend for a further 12 months up to a maximum term of three (3) years. The contract will commence on the 1st April 2021 and conclude on 31st March 2023, or 31st March 2024 if the optional extension is utilised.

2.6 Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).

Title	Fy21/22 £ (excl VAT)	FY22/23 £ (excl VAT)	FY23/24 £ (excl VAT)	Total £ (exc VAT)	Total £ (Inc. VAT)
Requirements	£3,560,892.00	£3,560,892.00	£3,560,892.00	£10,682,675.00	£12,819,210.00
Total	£3,560,892.00	£3,560,892.00	£3,560,892.00	£10,682,676.00	£12,819,210.00

Previous contract annual figures have fluctuated depending on demand and the four (4) year IT hardware replacement cycle. Also included in the above estimated figure are additional supported organisations that were not included in the previous contract so a direct comparison on value is not on a like for like basis.

The previous contract for 2019 – 2021 was a higher value of £13,357,140.00 (inc VAT) but this included a full GP refresh.

Value for Money (VfM) is ascertained by a like for like specification comparison per device.

2.7 Source of Funds

Ring-fenced GMS Funds will be used to fund the GP hardware. It is anticipated that NWIS / NWSSP Discretionary Capital funding will be used to fund their portion of the requirements, as applicable.

Sources of funding for other supported organisations such as HEIW, Radiology Imaging Academy, Prisons, Nursing Homes is unknown but funding streams must be confirmed before NWIS will order on their behalf and recharge.

3 DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a ***declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.*** Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:

Service Area:

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. SCHEME TITLE

LOGISTICS SOFTWARE

2. CONTRACT DETAILS

2.1. Description of Goods / Services / Works/ Lease

NHS Wales Health Courier Service is seeking a secure a logistics & patient transport scheduling system to schedule and plan its day to day logistics accessible through a secure logon procedure and operation of the system is through a user friendly interface.

The system will need to embrace the whole of the transport operation commencing with the receipt and registration of transport requests, planning of journey schedules, day control function for on the day requests, KPI reporting, contracting and charging.

2.2. Nature of Contract

(Please complete either 2.2.1 or 2.2.2).

2.2.1. New/First time contract

- **Date of Board approval of business case**
Not applicable
- **Issues to bring to Board's attention that differs from the detail within the approved business case.**
Not applicable.
- **Details of any matters that may be considered as Novel or contentious**
Not applicable

2.2.2. Contract Renewal/Extension

- **Description of Assessment undertaken to justify continuation of service requirement.**

This procurement concerns the renewal / re-procurement of Logistics Software currently with Cleric Ltd.

2.3. Procurement Route

NWSSP Procurement Services proposes to conduct a mini competition under Crown Commercial Service (CCS) Technology Services 2 (RM3804).

2.4. Timescales for implementation

It is anticipated the contract will be awarded in January 2021 with a six-month implementation period for configuration, development if a new supplier is awarded the contract.

2.5. Period of Contract

3 years with 2 year option to extend (1 + 1)

2.6. Maximum Expected Total Value of Contract – excluding and including VAT

Expenditure	Fy21/22 £ (excl VAT)	FY22/23 £ (excl VAT)	FY23/24 £ (excl VAT)	FY24/25 £ (excl VAT)	FY25/26 £ (excl VAT)	Total £ (Inc. VAT)
Software support and Maintenance	£62,000	£62,000	£62,000	£62,000	£62,000	£372,000
Monthly data collection	£18,000	£18,000	£18,000	£18,000	£18,000	£108,000
Total	£80,000	£80,000	£80,000	£80,000	£80,000	£480,000

2.7. Source of Funds

The required funds will be paid out of the revenue budget for existing contract.

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1. The lead Director, by signing this request for Board approval, is making a **declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.**

Signed:



Ymddiriedolaeth
GIG Felindre
Velindre NHS Trust

Print Name:

Job Title:

Date:

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT:

PRIMARY CARE STRATEGIC PLANNING – PREMISES FUTURE LOOK

2. CONTRACT DETAILS

2.1. Description of Goods / Services/ Works/Lease

The Welsh Government have instructed NWSSP-SES to procure Healthcare Planner services to undertake a Primary Care Strategic Planning exercise in relation to the NHS in Wales.

The commission will be procured using the Healthcare Planner Framework that is held by NWSSP-SES. This framework was procured by NWSSP-SES and NWSSP-Procurement and its duration is 1st May 2020 until 30th April 2024.

2.2. Nature of Contract

(Please complete either 2.2.1 or 2.2.2).

2.2.1. New/First time contract

This is a new commission with instructions coming from the Primary Care Team and Capital Estates and Facilities colleagues within Welsh Government. The Commission has the approval of the First Minister and the Health Minister. The commission duration will be November 2020 until 30th March 2021.

The Health Care Planners will be employed under the NEC Professional Services Contract with management through NWSSP-SES.

- **Date of Board approval of business case**

To be approved by NWSSP Committee on 15th November 2020.

- **Issues to bring to Board's attention that differs from the detail within the approved business case.**

Not applicable

- **Details of any matters that may be considered as Novel or contentious**

Not applicable

2.2.2. **Contract Renewal/Extension**

This is a new commission with instructions coming from the Primary Care Team and Capital Estates and Facilities colleagues within Welsh Government. The Commission has the approval of the First Minister and the Health Minister. The commission duration will be November 2020 until 30th March 2021.

The Health Care Planners will be employed under the NEC Professional Services Contract with management through NWSSP-SES.

2.3. **Procurement Route**

The Healthcare Planner Framework was advertised through OJEU prior to its launch. Therefore, the Healthcare Planners will be subject to a mini competition, interview and selection process. The interview panel will consist of Welsh Government Officials and Members of NWSSP-SES. The Welsh Government have provided a specification for the commission.

2.4. **Timescales for implementation**

The period of the contract is 5 months.

2.5. **Period of Contract**

The contract will commence on 1st December 2020 and complete on the 31st March 2021.

2.6. **Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).**

Title	FY20/21 £ (excl VAT)	FY21/22 £ (excl VAT)	Total £ (Inc. VAT)
	233,000		280,000
Total	233,000		280,000

2.7. **Source of Funds** **REVENUE**

The source of funds is a one off revenue payment from Welsh government to NWSSP-SES upon completion of the project.

3. **DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE**

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a ***declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.*** Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name: Neil Davies

Service Area: Specialist Estates Services

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. SCHEME TITLE

COHORT OCCUPATIONAL HEALTH SYSTEM

2. CONTRACT DETAILS

2.1. Description of Goods / Services / Works/ Lease

Software solution and maintenance thereof for the provision of occupational health clearance, ensuring safe recruitment standards are applied for pre-employment checks.

This procurement will ensure the continuance of an enhanced and resilient solution, via a 3rd party hosted solution, is delivered on an all Wales basis and ensure a bi-directional interface with the current ESR system.

The system supports the average number of days for a recruitment process to be completed, by reducing the number of days taken to complete the occupational health checks.

The delivery of Occupational Health services is currently being reviewed across NHS Wales with an option appraisal for future service model. It is anticipated that this work would have developed in the next twelve months to enable a solution to be tendered in line with the proposed 'new service model'.

2.2. Nature of Contract

(Please complete either 2.2.1 or 2.2.2).

2.2.1. New/First time contract

- ***Date of Board approval of business case***

Not applicable, paper has however been presented to the NWSSP Partnership Committee on the 15th November 2020 and consideration of this paper is subject to approval by them.

- ***Issues to bring to Board's attention that differs from the detail within the approved business case.***

Not applicable.

- **Details of any matters that may be considered as Novel or contentious**
The selected procurement route is not without risk, however as per point 2.3 below this is mitigated by the placement of a Voluntary Ex Ante Transparency Notice. A Supplier Engagement day has also been held and there are two suppliers who were able to provide a solution but without current bi-directional integration.

2.2.2. Contract Renewal/Extension

- ***Description of Assessment undertaken to justify continuation of service requirement.***

This procurement concerns the renewal of current agreements across Health Boards in Wales, with the current supplier Cohort. Further alignment and standardisation of the current disparate agreements will allow an all Wales approach to be established, via a single Occupational Health Solution with a single hosting solution. The renewal is further justified by the current review of the delivery of Occupational Health services in Wales and will enable this to happen without the potential disruption of migrating and implementing a new solution.

2.3. Procurement Route

A Supplier Engagement Day has been held and there are currently no other suppliers in the marketplace that are able to provide a compatible solution based on the current configuration as employee data is currently held by each Health Board. Further work needs to be done on the establishment of the bi-directional feed which is scheduled to be completed by the end of March 2021. The review of Occupational Health services should establish a single hosted solution that would be tendered.

Therefore a Single Tender Action (STA) for a duration of 1 +1 years will be drafted and submitted for approval. It is anticipated that by the end of the 1-year period a specification can be developed (dependant on the outcome of the National OH Service review). The specifications will reflect the delivery of the recommended solution to suppliers in the marketplace which will enable NHS Wales to undertake a competitive procurement process.

Due to the value of this requirement (over £106,000) a VEAT (Voluntary Ex-Anti Transparency) notice will be published in the OJEU. Subject to the successful completion of the mandatory standstill period, the contract will be awarded to Cohort. This risk is further mitigated in that potential future suppliers have already been engaged through a Supplier Day and advised of intentions.

2.4. Timescales for implementation

This will be determined in the PID and in consultation with the Health Boards the stakeholder anticipates that implementation will be completed within 12 months.

2.5. Period of Contract

1st December 2020 to 30th November 2021 with option to extend for 12 months.

2.6. Maximum Expected Total Value of Contract – excluding and including VAT

Table 1

Health Board/Trust	FY20/21	FY21/22	Overall
Aneurin Bevan	£18,223	£18,223	£36,446
Betsi Cadwaladr	£27,170	£27,170	£54,340
Cardiff & Vale	£16,514	£16,514	£33,028
Cwm Taf	£17,860	£17,860	£35,720
Hywel Dda	£17,865	£17,865	£35,730
Powys	£9,059	£9,059	£18,118
Swansea Bay	£21,550	£21,550	£43,100
WAST	£19,860	£19,860	£39,720
Total (exc. VAT)	£148,101.00	£148,101.00	£296,202.00
Total (inc. VAT)	£177,721.20	£177,721.20	£355,442.00

Table 1 outlines the funding required by shared services and that which is required from the Health Boards. Please note that there is no funding required from Velindre Trust as Velindre are not direct users of the system. The £148,102 will be paid up-front each year by NWSSP with recharge arrangements back to the Health Boards/Trusts. The full 1+1-year cost with and without VAT are detailed above and listed below.

(if contract renewal, please provide justification of difference in value from previous contract).

2 Year Cost £296,202 excluding VAT

2 Year Cost £355,442 including VAT

The contract is £26,280 more expensive than the current provision (per year) after deducting migration costs of £70,800 from the current arrangement. This is due

to an increase in licence numbers across UHBs. NHS Wales will also gain additional functionality from the inclusion of 'optional' modules being included into contract as standard. It will also allow for the continuance of the service through the current review of Occupational Health services.

2.7. Source of Funds

The required funds will be paid for out of the revenue budgets of the Health Board, the investment required by each Health Board is detailed above in Table 1 with NWSSP revenue budget supporting the delivery of an all Wales interface.

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1. The lead Director, by signing this request for Board approval, is making a ***declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.***

Signed:

Print Name:

Job Title:

Date:

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT: BOBARTH BUILDING LEASE

2. CONTRACT DETAILS

2.1. A five year lease outside of the 54 act. The lease will be granted on an FRI basis limited by a schedule of accommodation.

2.2. Nature of Contract (Please complete either 2.2.1 or 2.2.2).

2.2.1. This is a new contract. The proposal would require the Trust to enter into a lease for the former Bobarth Building on Park Road Whitchurch. The property is contained within the existing curtilage of the Cancer Centre.

2.2.2. If the Trust proceeds with this proposal the additional space made available allows the Trust to meet urgent requirements in respect of social distancing arising from Covid 19 restrictions and a facility to provide a respite area for front line staff.

Not applicable

- **Date of Board approval of business case**
- **Not applicable Issues to bring to Board's attention that differs from the detail within the approved business case.**

None

- **Details of any matters that may be considered as Novel or contentious**

Not applicable

2.2.2. Contract Renewal/Extension

Renewal of existing services.

2.3. Procurement Route

The lease has been negotiated by the property specialist team within Shared Services.

2.4. Timescales for implementation

The proposed completion date is December 18th 2020.

2.5. Period of Contract

The proposed lease term is 5 years with a Tenant only option to break the lease at any time after the 2nd anniversary, subject to giving the landlord no less than 12 months written prior notice.

The above is subject to a Tenant survey being carried out. The Tenant will take the property in its current condition but the repairing liability will be limited by a schedule of condition.

2.6. Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).

Title	Fy19/20 £ (excl VAT)	FY20/21 £ (excl VAT)	FY21/22 £ (excl VAT)	Total £ (Inc. VAT)
Lease	£3,541	£42,500	£42,500	£106,249
Rates	£5,687	£19,500	£19,500	£53,624
Utilities	£3,339	£13,357	£13,357	£36,064
Maintenance	£2,017	£6,918	£6,918	£19,024
Total	£14,584	£82,275	£82,275	£214,961

2.7. Source of Funds

The 20/21 source of funding is made available through non-recurrent COVID funding from Welsh Government. Should monies be made available for future years, the same source

of funding would be utilised. Failing Welsh Government direct funding support, the Trust will be required to prioritise the funding from within its existing revenue budget allocation.

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a ***declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.*** Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name: Mr Carl James

Service Area: Estates and Facilities

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT:

**GP AND PRIMARY CARE TEMPORARY WORKFORCE ENGAGEMENT PORTAL
AND REPORTING**

2. CONTRACT DETAILS

2.1. Description of Goods / Services/ Works/Lease

A contract was established in December 2019 utilising an open tender process for the provision of a software solution. The system, known as GPWales, provides an on line portal to facilitate the matching of Locums with Practices and includes reporting functionality that can be used to inform sustainable workforce strategies. The contract was ratified by Velindre Board in July 2019.

Whilst the original specification included functionality for Out of Hours/111 Services, further scoping with Stephen James, National workforce Lead, 111 Programme has identified a more complex requirement to meet the current and planned future developments of the service.

As there is a commitment to provide a Once for Wales solution for Primary Care Workforce opportunities, Welsh Government identified the opportunity to expand the system. To make the current GPWales platform fit to cater for Out of Hours/111 service demands, a number of key modifications are required:

- Infrastructure changes to accommodate multiple shift types and multiple locations;
- Viewing adjustments that will allow users to see Locum and OOH/111 shifts alongside one another to increase the fill rate.

The sourcing and delivery of this solution is driven by Welsh Government.

2.2. Nature of Contract

(Please complete either 2.2.1 or 2.2.2).

2.2.1. New/First time contract

Not applicable

- **Date of Board approval of business case**

Not applicable

- **Issues to bring to Board's attention that differs from the detail within the approved business case.**

Not applicable

- **Details of any matters that may be considered as Novel or contentious**

Not applicable

2.2.2. **Contract Addition**

Original Contract approved on 19th December 2019 as identified below. This request is for an increase in value to the current contract in line with the existing timeframe. The additional value is within the acceptable range for amending an existing contract eg the additional value is less than 50%.

2.3. **Procurement Route**

EU Open Procedure in accordance with PCR2015 Ref: NWSSP-OJEU-42595

2.4. **Timescales for implementation**

There is a requirement for this additional functionality to be delivered within this Financial Year. Development will commence in December and be completed by March 2021.

2.5. **Period of Contract (Existing Contract term)**

19th December 2019 to 30th November 2022 with option to extend for a further 3 years in annual increments.

2.6. **Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).**

Original contract value:

Title	Yr 1 £ (excl VAT)	Yr 2 £ (excl VAT)	Yr 3 £ (excl VAT)	Extension option years (x3) (excl VAT)	Total £ (Inc. VAT)
GP Temporary Workforce tool	388,340	73,025	73,575	224,082	£910,826

Additional requested spend:

Title	FY20/21 £ (excl VAT)	FY21/22 £ (excl VAT)	FY22/23 £ (excl VAT)	Extension option years (x3) (excl VAT)	Total £ (Inc. VAT)
OOH/111	171,360	10,080	6,720	30,240	£262,080

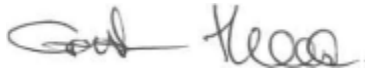
2.7. **Source of Funds**

This scheme is funded by Welsh Government in its entirety.

3. **DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE**

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a ***declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.*** Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name: Gareth Hardacre



Service Area: Workforce Organisational Development and Employment Services

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT:

ALL WALES ALLOCATE E-ROSTERING CONTRACT

2. CONTRACT DETAILS

2.1. Description of Goods / Services/ Works/Lease

Purchase of Allocate HealthRoster Optima Software [hosted solution] plus implementation support services

2.2. Nature of Contract

(Please complete either 2.2.1 or 2.2.2).

2.2.1. New/First time contract

Not applicable

- **Date of Board approval of business case**

Not applicable

- **Issues to bring to Board's attention that differs from the detail within the approved business case.**

Not applicable

- **Details of any matters that may be considered as Novel or contentious**

Not applicable

2.2.2. Contract Renewal/Extension

Renewal of existing services - Allocate Software currently provide their rostering product to 6 of 7 Health Boards/Trusts in Wales with differing pricing structures and packages in each UHB. A procurement exercise has been undertaken to and agreed that a new 'All Wales contract' with a consistent pricing schedule across NHS Wales would be procured via NHS Wales Shared Services Partnership on behalf of the service. The renewal provides the opportunity to widen the offering of the software to numerous other NHS Wales organisations, including Velindre NHS Trust. The contract will also simultaneously incorporate the addition of 'Safecare', a daily staffing software that matches staffing levels to patient acuity and dependency, thus supporting the Nurse Staffing Levels (Wales) Act 2016.

2.3. Procurement Route

The contract will be awarded via the Health Trust Europe ICT Solutions 2 framework. Allocate's SaaS terms are available on this framework via the vendor Softcat. Therefore, the agreement will be placed as a direct award via Softcat as a reseller.

The contract will be governed by the Terms and Conditions of the HTE framework, ensuring protection for the contracting authority and minimal financial risk as the checks are carried out on our behalf by the framework provider.

Rates have been subject to commercial review and discussions, ongoing since November 2019. Allocate have reviewed their list prices, provided sizable discounts and a reduced APR. All costs are inclusive of the Softcat fee.

The direct award approach is compliant with regard to the framework and compliant in terms of Public Contracts Regulations 2015.

2.4. Timescales for implementation

Contract to be awarded 01 December 2020.

System implementation timescales will differ for each UHB dependant on their Rostering maturity.

2.5. Period of Contract 5 Years

2.6. Maximum Expected Total Value of Contract – excluding and including VAT (if contract renewal, please provide justification of difference in value from previous contract).

NWSSP has realised savings for existing customers against current prices for several organisations, and significant savings against the list price due to the All Wales buying power. A single All-Wales unit price has also been agreed to support any additional licence requirement for the duration of the contract. Additional savings have been realised with the agreement of a 3% APR as opposed to 5%.

Where cost increase for existing HealthBoard customers, they are receiving significant system additionality to the service they currently receive i.e. the addition of Safecare, Insight and ESR go to their contracts [Tabled at DOFs on 18th September 2020].

Costs per UHB are as Follows:

	AB	BCU	CTM	C&V	HDda	NWSSP	Powys	PHW	SBU	Velindre	AW annual Total
No of licences	9,000	15,000	7,500	10,000	5,200	600	2,000	600	9,600	600	61,900
Health Roster Optima (Rostering)											
AW Annual Licence fee	£198,000	£262,350	165,000	220,000	114,400	13,200	44,000	13,200	167,904	13,200	£1,211,254
Insight reporting tool											
AW Annual Licence fee	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	£25,000	250,000
One off -Health Roster Optima - Implementation Service fees											
• SafeCare	£28,000		£28,000								£56,000
• ESR Go		£16,900	£16,900	£16,900		£16,900		£16,900		£16,900	101,400
• Optima				£150,000		£59,800		£59,800			£269,600
Collaborative Bank (Optional)											
AW Annual Cloudstaff licence fee	£5,000	£5,000	£5,000	£5,000	£5,000	£5,000	£5,000	£5,000	£5,000	£5,000	£50,000
10,000 Shift bundles	£6,800	£6,800	£6,800	£6,800	£6,800	£6,800	£6,800	£6,800	£6,800	£6,800	£68,000
One off - Collaborative Bank (Optional) Implementation fees											
implementation	£3,600	£3,600		£3,600	£3,600	£3,600	£3,600	£3,600		£3,600	£28,800

Costs for the entire contract over 5 years including 3% uplift per annum :-

Title	Fy20/21 £ (excl VAT)	FY20/22 £ (excl VAT)	FY21/23 £ (excl VAT)	FY23/24 £ (excl VAT)	FY24/25 £ (excl VAT)	Total £ (excl. VAT)
Optima System Insight Reporting CloudStaff	£1,579,254	£1,626,632	£1,675,431	£1,725,693	£1,777,464	£8,384,474
Implementation Fees	£455,800	-	-	-	-	£455,800
Total	£2,035,054	£1,626,632	£1,675,431	£1,725,693	£1,777,464	

2.7. Source of Funds

The contract will be awarded as a SaaS contract and therefore funding is entirely Revenue.

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a ***declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with.*** Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:

*Gareth Hardacre,
Director of Workforce & OD and Employment Services
NHS Wales Shared Service Partnership*

Decision: The Velindre NHS Board are asked to approve the expenditure in principle, to enable NWSSP to proceed to awarding a contract in December 2020 once the outcome of the WG funding is known.



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TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	26/11/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance

REPORT PURPOSE	CONSIDER and ENDORSE
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME
Trust Board Members – Via Email	16/10/2020	Approved
Trust Board Members – Via Email	23/10/2020	Approved – two requests
Trust Board Members – Via Email	11/11/2020	Approved

ACRONYMS

TCS	Transforming Cancer Services Programme
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

- 1.1 In accordance with Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Board Secretary, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded, and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.
- 1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.
- 1.3 The Vice-Chair was invited and agreed to attend the NWSSP Financial Governance Group that has been established to oversee and scrutinise NWSSP procurement requests in response to COVID 19 PPE requirements. The Board has agreed that due to the role performed by the Vice-Chair on this group, the Vice-Chair will abstain from any approval requests sought via Chairs Urgent Action involving NWSSP procurement decisions.
- 1.4 This report details Chair's Urgent Action taken since the last Trust Board meeting held on the 24 September 2020 up to the 13 November 2020.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

The items outlined in Appendix 1 have been dealt with by Chairs Urgent Action.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
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.



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FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

- 4.1 The Board is asked to **CONSIDER** and **ENDORSE** the Chairs urgent action taken since the 24 September 2020 Trust Board Meeting as outlined in Appendix 1.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. NWSSP - Purchase of COVID 19 FFP3 Respirator Masks

The Trust Board were sent an email on the 16 October 2020, inviting the Board to **AUTHORISE** expenditure in relation to the Purchase of COVID 19 FFP3 Respirator Masks.

Due to the urgency of this matter, it could not wait until the 26 November 2020 Trust Board meeting.

Recommendation Approved:

- Mrs. Donna Mead, Chair
- Mr. Steve Ham, Chief Executive Officer
- Mr. Gareth Jones, Independent Member
- Mrs. Hilary Jones, Independent Member

No objections to approval were received.

2. Transforming Cancer Services (TCS) Planning Approach

The Trust Board were sent an email on the 23 October 2020, inviting the Board to **AUTHORISE** the proposed planning approach for the TCS Programme.

Due to the urgency of this matter, it could not wait until the 26 November 2020 Trust Board meeting.

Recommendation Approved:

Mr. Stephen Harries, Acting Chair
Mr. Steve Ham, Chief Executive Officer
Mr. Martin Veale, Independent Member
Mrs. Hilary Jones, Independent Member
Mrs. Janet Pickles, Independent Member

No objections to approval were received.

3. Velindre University NHS Trust Quarter 3 – Quarter 4 Operating Plan

The Trust Board were sent an email on 23 October 2020, inviting the Board to **AUTHORISE** the submission of the Velindre University NHS Trust Quarter 3 – Quarter 4 Operating Plan for submission to Welsh Government.

Due to the urgency of the above activity, this matter could not wait until the 26 November 2020 Trust Board meeting.

Recommendation Approved:

Mr. Stephen Harries, Acting Chair
Mr. Steve Ham, Chief Executive Officer
Mr. Martin Veale, Independent Member
Mrs. Hilary Jones, Independent Member
Mrs. Janet Pickles, Independent Member

No objections to approval received.

4. NWSSP - Purchase of COVID 19 FFP3 Respirator Masks

The Trust Board were sent an email on the 11 November 2020, inviting the Board to **AUTHORISE** expenditure in relation to the Purchase of COVID 19 FFP3 Respirator Masks.

Due to the urgency of this matter, it could not wait until the 26 November 2020 Trust Board meeting.

Recommendation Approved:

- Mrs. Donna Mead, Chair
- Mr. Steve Ham, Chief Executive Officer
- Mr. Gareth Jones, Independent Member
- Mr. Martin Veale, Independent Member
- Mrs. Jan Pickles, Independent Member
- Mrs. Sarah Morley, Executive Director

Some clarifications were requested and subsequently addressed in order for the Board to approve this request. No objections to approval were received.



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Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD

POLICIES FOR APPROVAL

DATE OF MEETING

26/11/2020

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE INDICATE REASON

Not Applicable - Public Report

PREPARED BY

Catherine Currier, Business Support Officer &
Emma Stephens, Head of Corporate Governance

PRESENTED BY

Lauren Fear,
Director of Corporate Governance

EXECUTIVE SPONSOR APPROVED

Lauren Fear,
Director of Corporate Governance

REPORT PURPOSE

FOR APPROVAL

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

COMMITTEE OR GROUP

DATE

OUTCOME

Not applicable

(DD/MM/YYYY)

Choose an item.

ACRONYMS

EMB

Executive Management Board

1. SITUATION/BACKGROUND

- 1.1 In accordance with the “Policy for the Management of Policies, Procedures and other Written Control Documents”, the Trust Board will receive all approved policy documents for information under the consent agenda.
- 1.2 The purpose of this report is for the Trust Board to note the policies that have been approved since the last report in September 2020.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 As agreed in the Recovery Plan approach in April, various matters of business that would have ordinarily been dealt with in one of the Committees that are currently paused, has instead been transferred to the Trust Board. Approval is therefore sought from Trust Board for the following Policies:

Policy Title	Policy Lead/ Function	Approving Committee	Effective Date If Approved
All Wales Lease Car/Pool Vehicle Policy & Procedure (Ref: FP 03)	Shared Services Partnership	All Wales Policy/ Procedure	September 2020

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Trust has a defined process for the management of policies and written control documents. The purpose of which is to ensure staff are aware of their responsibilities with regards to Trust policy documents and to provide a ‘model’ guide and consistent approach for the development, management and dissemination of the Trusts documents
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.



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FINANCIAL IMPLICATIONS/ IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Trust Board is asked to **APPROVE** the:

- All Wales Lease Car/Pool Vehicle Policy & Procedure (Appendix 1 - Ref: FP 03)

All Wales Lease Car/Pool Vehicle Policy and Procedure

Policy Code	Date	Version Number	Planned Review Date
V001	June 2016	Version 1	June 2019
	September 2020	Version 2	September 2023
Document Owner		Approved by	Date
NWSSP - Employment Services - Head Of Payroll Services		DDOF Meeting	14.08.20

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VALIDATION & RATIFICATION

To be completed by the Author – no policy, procedure or guidance will be accepted without completion of this section which must remain part of the policy

Title: All Wales Lease Car/ Pool Car Policy and Procedure

Author: Head of Payroll Services

Directorate: NWSSP – Employment Services

Approved for submission by:

Date:

EVIDENCE BASE

Are there national guidelines, policies, legislation or standards relating to this subject area?

If yes, please include below:

- National Agenda For Change guidelines
- HMRC legislation

If No, please provide information on the evidence/expert opinion upon which the policy has been based.

CONSULTATION

Please set out the arrangements undertaken and stakeholder groups involved in the development and consultation process:

- Created by Beverley Cokeley
- Sent for Approval to Paul Thomas (Director Of Employment Services)
- Circulated to All Wales Finance Directors & All Wales Workforce & OD Directors and Staff Side at SMT for ratification (this document forms part of NWSSP SLA).
- Publicised on All Wales Health Board/Trust Intranet pages

IMPLICATIONS

Please state any training implications as a result of implementing the policy / procedure.

No training implications as individual policies and procedures are currently in force in Health Boards/Trust across Wales

Please state any resource implications associated with the implementation.
none

Please state any other implications which may arise from the implementation of this policy/procedure.

none

Equality Assessment Statement – TO BE COMPLETED

Please complete the following table to state whether the following groups will be adversely, positively, differentially affected by the policy or that the policy will have no affect at all

Equality Statement					
	No impact	Adverse	Deferential	Positive	Comments
Age	X				
Disability	X				
Gender	X				
Race	X				
Religion/Beliefs	X				
Sexual Orientation	X				
Welsh Language	X				
Human Rights	x				

Risk Assessment

Are there any risks arising from the implementation of this policy? No
Do you believe that they are adequately controlled? N/a

1. NHS All Wales Lease Car Policy and Procedure

1.1 Introduction

This sets out the terms and conditions of the All Wales Lease Car scheme adopted by the Health Board(s) and Trust(s) across Wales for the provision of Leased vehicles to staff in line with Annex M of the A4C handbook and M&D Policy; this policy replaces any previous policies in place for lease cars. The aim of the policy is to be fair and consistent to all individuals and assist Health Boards/Trusts in providing an efficient and effective administration Service to the NHS staff across Wales.

1.2 This Policy takes into account the following key principles:

- To be available for all staff who are required to travel as part of their role within the Health Board/Trust.
- That the financial implications are clearly set out for the individual.
- That the financial implications are clearly set out for the Health Board/Trust.
- That any Lease Car Agreement approved is no worse than cost neutral to the Health Board in comparison with Travel expenses.
- That the agreement is tax efficient for individual and organisation.
- The scheme provides choice for staff whilst cost to Health Board/Trust of travel is firmly controlled, and if possible, reduced.
- There should be no incentives or penalties tied to the scheme with free access in or out of it (except for early termination charges on lease agreements).
- The scheme is simple to administer and easy for all staff to understand.
- The scheme is flexible and able to adapt to future changes in Travel Expenses terms.
- The scheme should be as environmentally sustainable as possible. Staff should note that the provision of a Leased Car scheme is discretionary on the part of the Health Board/Trust. It is provided as a cost neutral staff benefit, as an alternative to reimbursement of NHS mileage rates at current rates paid for the use of a private vehicle and is open to all staff on that basis. Where disabled staff are required to have modifications to a vehicle this can only be with the express approval of the leasing company. The costs of modifications will be considered as part of the lease car costs and treated in accordance with this policy.
- All Lease Car Vehicles will include Standard Safety Packs:- Warning Triangle/Beacon, Din First Aid Kit, Life Hammer, 1kg Fire Extinguisher, Hi-Vis Vest & Mechanical Relief Vehicle.
- The scheme is offered to all employees of the Health Board/Trust who are required to be mobile and where the Health Board/Trust considers there is an economic case to provide a Lease Car. Generally speaking the Health Board/Trust will not normally consider providing a Leased vehicle to staff who travel less than 3500 business miles or who are on temporary contracts of employment. Applications that do not meet this requirement will be subject of approval of the Director of Workforce & OD or their nominated representative.

- This scheme does not form part of an employee's Terms and Conditions of employment and the Scheme may be varied or withdrawn at any time. Nothing in this document shall be inferred as conferring rights.
- Notwithstanding the above, other than for changes in Road Fund License (or other tax e.g. VAT), Insurance premiums or underpinning Travel Expense rates, the Health Board/Trust will normally only implement changes to the scheme architecture at the end of the lease period.
- Participation in the scheme is entirely voluntary and staff may revert to claim travel expenses for a private vehicle at the end of the lease period, under the appropriate terms at that time.
- The lease period is for three years. However if for reasons supported by the Health Board/Trust whereby a further period needs to be considered the only exception for this extension is for organisational change and/or retirement.
- The choice of vehicle would be left to the driver, but Health Boards/Trusts retain the right to ensure that the lease vehicle meets the "Green" criteria emissions in 2020.
Finance Bill 2020 introduces primary legislation to clarify that all new cars provided to employees and available for private use which are first registered from 6 April 2020 will be taxed according to the CO2 emissions figure measured under the WLTP procedure.
- Health Board/Trust liability will be restricted to the total cost that would have been incurred had the individual used their own car and been paid travel expenses under A4C and Medical & Dental Terms and Conditions for Standard users at the time of the application.

1.3 The information contained in this policy is subject to changes in legislation. Staff should be aware that a lease car is considered to be a "company car" and remains the property of the Leasing Company during the period of the lease. It will therefore be subject to taxation as a benefit in kind. Please contact your tax office for further information.

1.4 This policy applies to all grades of staff within the Health Board/Trust including Directors, Board Members and Medical and Dental Officers. PLEASE NOTE – for staff transferring from one Health Board/Trust in Wales to another can request to bring their lease car with them. The agreement from the Directorate Manager MUST be received by the NWSSP Lease Car Department before the vehicle can be transferred. Without this agreement in place, the vehicle CANNOT be covered by the Health Board/Trust insurance. At the time of the transfer where a vehicle is existing on a local Health Board/Trust Lease Car policy the terms and conditions will be revised under this All Wales Lease Car Policy. Where a lease car is transferring under TUPE arrangements the terms and conditions will remain the same until the end of the lease contract for that vehicle at which time any renewal will come under the All Wales Lease Car Policy.

1.5 The drivers will be responsible for supplying a printout or a code number via the on-line DVLA website where NWSSP Lease Car Office is given authorisation to obtain a copy of the driving licence details including any convictions/penalty

points. This includes full details as above on any subsequent nominated authorised driver which would normally reside at the principle driver's address holding a full clean driving licence for a minimum of one year over the age of 18. Please note until NWSSP Lease Car Office are in receipt of the licence details no order can be placed for the lease car vehicle.

2 Benefit in Kind Liabilities

Taxation

From 6th of April 2002 the taxable liability of a company car is determined by its carbon dioxide (CO₂) emission. This legislation was introduced in an effort to encourage selection of cleaner and more fuel-efficient vehicles. This information is subject to change at any time by the HMRC.

The tax liability is based upon a percentage of the car's list price graduated according to the level of the car's CO₂ emissions. The exact CO₂, which is measured in grams per kilometre, is rounded down to the nearest 5g/km. Details of the scale charge are available from HMRC website (www.hmrc.gov.uk).

3 Applying for a Car

3.1 Think Carefully!

This Policy sets out the terms and conditions under which NWSSP will administer on behalf of the Health Board(s)/Trust across All Wales to provide Lease Car vehicles to members of staff.

STAFF WHO APPLY AND ARE ALLOCATED A LEASE CAR VEHICLE UNDER THIS SCHEME ARE DEEMED TO HAVE ACCEPTED AND READ THE CONDITIONS AS SET OUT BELOW:

When an individual member of staff decides that they would like to apply for a lease car they should, in the first instance satisfy themselves of the following:

3.1.1 That they have read and understood the terms of the scheme and appreciate the basis on which the vehicle is being made available including how the Lease Car charge is made up.

3.1.2 That they clearly understand that the vehicle is not available for any purpose other than Health Board/Trust business and their personal social domestic and pleasure use. The Lease Car may not be used for hire and reward, racing, pacesetting or any business uses other than for Health Board/Trust business.

3.1.3 That they are aware that the vehicle will be new and that Lease Car charges

include the cost of depreciation (purchase cost to the leasing company less what it estimates it can sell the car at the end of the lease), and a fixed sum to cover servicing and repairs in accordance with manufacturers stipulations (all contracts include servicing and maintenance), Road Fund License (RFL), MOT, Insurance and mechanical relief services.

3.1.4 That the Lease Car Charge includes an annual administration charge that covers the costs of the administration of the scheme on behalf of the Health Board/Trust.

3.1.5 That they are responsible for the general care for the vehicle, ensuring it is regularly serviced by a manufacture's approved agent and is not subjected to abuse. They understand that any charges levied by the leasing company during or at the end of a contract relating to damage outside the company's fair wear and tear scheme will be passed on to the driver.

3.1.6 That they understand current legislation with regard to company car taxation. That is to say that the car is a "benefit in kind" and as such will attract National Insurance contributions (deducted from pay as part of the private use charge by the Health Board/Trust) and Income Tax (not part of the private use charge). Income Tax is taken by the Inland Revenue by adjustment of an individual's tax code.

3.1.7 That they can afford the terms and length of the leasing commitment for three years in duration. If at any time the user, through their own choice, wishes to return the car they will be responsible for the payment of any early termination charge by the Lease Car Company.

3.1.8 Lease Cars are designated Health Board/Trust vehicles. There is a strict No Smoking policy and the safe use of mobile phones which applies to all Leased Car drivers as it does to all other Health Board/Trust vehicles. This policy applies when the vehicle is used for BOTH business and private use and this could result in disciplinary action being taken against the employee.

3.1.9 They understand that the key determinate of the cost of a particular vehicle is the total contract mileage. You should not underestimate private mileage or overestimate business miles in order to either reduce the private contribution or to overstate the allowance due. Cars returning over contract mileage are charged for at a set rate per mile and these charges will be passed on where appropriate. This charge also applies to cars which are returned under contract for business mileage where the allowance has been calculated more favourably due to managers/employees overstating official mileage. It is important that both manager and employee agree on the realistic mileage for both official and private use before a lease car is formally considered.

3.1.10 They understand current legislation with regard to company car taxation. That is to say that the car is a "benefit in kind" and as such will

attract Tax in each year following the submission of form P11d to HMRC. Income tax is taken by the HMRC by adjustment to the individuals' tax code.

3.1.11 Business mileage will be paid at HMRC Company Car Rates.

3.2 If the individual decides that they want to proceed with a lease car application they should collect the following information:

- An estimate of annual private mileage. This will include the journey to and from their normal workplace however no mileage can be claimed/paid for any journeys that involve home to base mileage (classed as Commuting under HMRC rules) which includes excess, on call/call out and overtime mileages as any of this mileage claimed and paid will incur a fuel benefit charge to the employee.
- The make, model, engine size, fuel type (petrol/diesel/dual fuel/electric), number of doors, paint colour and type (solid/pearlescent/metallic) and any factory fit or dealer options they wish to have quoted for up to 6 cars and further quotes requested will attract an additional administration fee.
- A copy of the full driving licence will be obtained via the DVLA website including any convictions or penalty points for each driver as in 1.5 above.

3.3 The applicant should submit this information on the NHS All Wales Lease Car Application Form (Appendix 1) or can be obtained by contacting lease.cars@wales.nhs.uk to their line manager who will be required to authorise the estimated business mileage as being correct.

For reference the applicant should keep copies of the All Wales Lease Car Application Form. Managers should be aware that it is their duty to ensure that all business mileage estimates are realistic. Once the business mileage is authorised and a car ordered it cannot be varied.

The Line Manager is responsible for submitting the authorised form including the appropriate signature of the Directorate to the NWSSP Lease Car Officer in the Payroll Services Department, Lease Car Section preferably by e-mail to lease.cars@wales.nhs.uk or by post to Matrix House, Northern Boulevard, Matrix Park, Swansea Enterprise Park, Swansea SA6 8BX who will obtain quotations for the selected vehicles at the stated mileage from a panel of approved leasing companies via the National Framework System.

If a lease car contract expires prior to or during maternity leave absence and the Department Manager and the Employee have signed a new lease car contract this is based on the employee qualifying for a lease car upon their return to work. However, if circumstances change upon the return to work and the employee no longer qualifies for a lease car it is the responsibility of the Department Manager to pick up the full cost of any termination fees that apply.

- 3.4 NOTE** Staff in receipt of Excess Mileage may qualify for a lease car however any claim for excess mileage will then be classed as private mileage and therefore no further reimbursement will be paid. Staff who under organisational change are forced to move their base while in a current lease car contract, any claims for excess can be treated as notional mileage during the period of their current lease car contract. Each case will be assessed individually however, it is unlikely that staff in receipt of excess mileage will qualify for a lease car due to the Tax implications of incurring a fuel scale charge.
- 3.5** Once the authorised documentation has been received the Lease Car Officer will calculate the private use contribution using the formula detailed in section 4. A full quotation will be returned to the applicant together with a letter outlining the administration process, who will have 14 days from the quotation date to accept one of the quotes by completing the appropriate forms regarding information on the chosen car, signing and returning the appropriate page to the Lease Car Officer in Payroll Services, Lease Car Department as in 3.4. The NWSSP Lease Car Officer will place the official order for the car. The NWSSP Lease Car Officer will check the application form and any other documentation, and place the order but any subsequent alterations made by the employee may incur additional charges.
- 3.6** If at any time between the acceptance of a quote and the placing of an order a change to the availability or specification of the chosen car occurs the Lease Car Officer will contact the applicant via email and will require written agreement to any change in specification or cost before the order is placed. The acceptance of a quote does not bind the Health Board/Trust to provide a car at the quoted specification or cost where it is unable to do so due to factors beyond its control (e.g. manufactures price increase, delivery delays or shortages of particular models). The timescale from the date of order to the delivery date can take between a period of three and seven months depending on the manufacturers availability of the requested vehicle.
- 3.7** Once the order has been placed and confirmed by the Leasing Company, the NWSSP Lease Car Officer will notify the applicant/driver to arrange delivery directly with the leasing company. The employee **only** will be responsible for receiving the car and inspecting it, bringing any concerns to the attention of the delivery person immediately. The employee **only** is required to sign the leasing companies delivery note accepting delivery, these forms should be forwarded to the Lease Car Officer as in 3.4 and held on the appropriate lease car file for the individual.

4 The Calculation of Private Use Charges

4.1 Table 1 – Example pricing calculation Ford EcoSport 1.0 EcoBoost Zetec (illustrative only)

Example of Cost of Lease Car and Contribution based on above illustration:-

EMPLOYEE DETAILS					
Name:			Staff Number:		
Annual Business Mileage:	7000		Annual Private Mileage:	7000	
Total Annual Mileage:	14000		Department:	AFC	
VEHICLE DETAILS					
Car Description:	Ford EcoSport 1.0 EcoBoost Zetec				
Optional Extras:					
Paint Finish:	Solid		Engine (cc) / Fuel Type:	<1000cc	Petrol
P11D Value:	£17,625	Additional Cost	Co2 Emissions:	121	25.00%
Notes:					
LEASE CAR CONTRIBUTION CALCULATOR					
Quoted Vehicle Annual Contract Hire	£2,279.76		Including maintenance, relief and RFL excl VAT		
Deduct Initial RFL	£165.00		First tax disc taken out at first registration		
Cost of Averaged RFL	£148.33		3 years averaged std rates against Co2		
Annual Additional RFL	£0.00		List price above £40,000 but CO2 below 180		
Averaged Additional RFL	£0.00		3 year averaged additional RFL		
Net Vehicle Annual Contract Hire	£2,263.09				
Handling Charge	£150.00		To cover quotes, ordering & admin support		
Insurance	£531.94		Charge per vehicle inc claims management		
Lease Car Business Miles	£770.00		Fuel reimbursement to be claimed separately		
GROSS COST	£3,715.03				
Less Mileage Allowance	£3,150.00		Health board contribution (Afc/MD Business Mileage rate per mile)		
GROSS COST LESS HB CONTRIBUTION	£565.03		HMRC Company Fuel mileage rate		
Estimated Class 1A NIC	£495.13		Charged on benefit in kind		
VAT Output Tax	20.00%	£212.03	Supply of goods is liable for VAT		
Charge to Employee Per Annum	£1,272.20		1/12th to be deducted from salary each month (Subject to minimum fixed costs charge)		
PAYROLL BREAKDOWN					
Charge to Employee Per Month	£106.02				
Private Use	£88.35				
VAT	£17.67				
BENEFIT IN KIND CALCULATION					
P11D Value	£17,625.00		*The Impact on take home pay of the Benefit In Kind and deducted monthly from the individuals tax code by the HMRC		
BIK Rate	£0.25				
BIK Gross	£4,406.25				
Annual Charge	£1,272.20				
Benefit in Kind	£3,134.05				
20%*	£52.23				
40%*	£104.47				
45%*	£117.53				

- 4.2** The current rates for road fund licence, fuel reimbursement, insurance, employers national insurance, administration charge and VAT are also detailed on a quotation. These are subject to review from time to time.
- 4.3** Once a quote has been accepted and the vehicle ordered, the monthly charge will only change due to one or more of the following:
- Changes in road fund licence costs due to legislation.
 - Insurance is renewed annually and any additional costs or savings are passed on to users.
 - Changes in VAT.
 - Changes in class 1A national insurance rates
 - Changes in taxation banding on CO₂ emissions

5 Conditions of Use

5.1 Mileage Claims

The user is required to submit monthly mileage claims via SEL Expenses on a monthly basis. Business Mileage is paid at the HMRC Approved Company car rates which are reviewed every quarter by HMRC. Failure to submit claims on a monthly basis could lead to the withdrawal of fuel reimbursement until such time as the user has submitted any missing claims. It may also result in all mileage being classed as private use.

5.2 Official Passengers & Heavy Bulk

Official passengers may be carried in Lease Cars. But no reimbursement can be claimed for passenger carriage or Heavy Bulk Equipment.

5.3 Changes in Mileages

During the term of the lease if the employee wishes to decrease or increase the contract mileage significantly they must inform NWSSP Lease Car Office immediately where the NWSSP Lease Car Officer will seek guidance from the Leasing Company.

5.4 Insurance

The vehicle will be insured by the Health Board/Trust for business, study leave and social/domestic and pleasure use only for as long as the user remains an employee of the Health Board/Trust. Full details of the insurance policy in force will be circulated to users on renewal. This will include excess levels under the policy. Usually the policy will include a minimum policy excess which is the drivers

liability and additional excesses for young, inexperienced drivers or those with previous convictions for traffic offences who are employed by the Health Board/Trust. The Health Board/Trust reserves the right to refuse applications from employees with a poor-driving record. On renewal any increase or decrease in premium will be passed on to Lease Car Drivers. The vehicle will not be insured for provisional licence holders.

5.5 Accidents

As with any motoring accident the driver should ensure that he/she obtains full particulars (vehicle registration, make, colour, drivers name and address, driver's insurance policy number and company) from the other party/parties involved. Where possible they should also obtain the name and address of any witnesses and the name and number of any police officer who attends. At no time should they admit liability without the advice of the Insurance Company. **Users must contact the Insurance Company immediately and within 24 hours to report the accident** as stated on the Claims handling information supplied to you by the Lease Car Team, as it is the Insurance Company who must advise you of the action to be taken. Approval to commence repairs can only be given by the Insurance Company. All damage to the vehicle must be notified to the Insurance Company. The driver will be liable for the insurance excess charge where there is a third party involved, however, should the third party be found at fault this excess will be refunded to the driver. Where an accident occurs where there is no third party involved the driver will be liable for the insurance excess.

5.6 Motoring Offences

On application of a lease car the individual must issue the code number for the DVLA website for the NWSSP Lease Car Officer to obtain the licence details and details of any motoring convictions. It is the responsibility of the driver to ensure that, after these details have been obtained, any future convictions, for which points are awarded, are notified to the NWSSP Lease car officer immediately.

5.7 Fixed Penalty Offences & Parking Fines

Any fixed penalty offences/parking fines/congestion charges relating to the lease car will be the responsibility of the named driver.

In the instance of a camera fixed penalty notice the leasing company will automatically receive the penalty which will be automatically paid by the leasing company and sent to the NWSSP Lease Car Office, which will then be passed onto the relevant driver even where a nominated driver has incurred this charge.

Where the driver or nominated driver has incurred a fixed penalty parking fine (placed to the window) if the driver is in dispute they must return the dispute immediately to the penalty issuer to avoid any additional costs. If the driver is in dispute with a parking offence and has failed to notify the issuer by the given date (usually 14 days) and subsequently a fine is received into the NWSSP Lease Car Office this fine will be paid on behalf of the Health Board/Trust and the driver notified of the charges which will then be deducted from the next pay period, this is to avoid any further escalation of charges and bailiffs arriving at NWSSP to recover the monies owed by Health Board/Trust staff.

5.7.1 Additional Administration Charges

The named driver will incur an Additional Administration Charge applied separately by the Leasing Company and NWSSP Lease Car department for the handling of any unpaid fixed penalty offences/parking fines/congestion charges relating to a Lease Car.

5.8 Travel Abroad

Before travelling abroad with a lease vehicle, the employee will be required to notify the Leasing Company who will arrange details accordingly this requires min of 28 days notice. You will also be required to take out your own adequate personal travel insurance as the lease car insurance will only cover the vehicle.

5.9 Wear and Tear

5.9.1 Whilst it is acceptable that a vehicle is subject to reasonable wear and tear during its life the leasing company's interpretation of 'fair wear and tear' is usually very closely drawn. Excluded are such things as:

- Glass Breakage (windows and lights)
- Punctures
- 'Kerbing' damage to tyres and wheels
- Stone chipping where the paint is broken and rusting has started
- Scratches to paintwork and bumpers
- Holes left by the removal of mobile phones
- Stained, torn or cigarette burned upholstery
- Mechanical failure due to abuse or incorrect servicing
- Valeting of the car where proper care has not been taken.

It is in the employee's interest to ensure that the above are repaired at the time they occur, or at the time the car is serviced as per BVRLA guidelines (British Vehicle Road Licence Association) (copy available from NWSSP Lease Car Office).

5.9.2 The Health Board/Trust will be invoiced for damages as listed in 5.9.1 and where it is clear that they are the result of private use, careless business use or a failure to properly care for the vehicle these charges will be passed to the user.

6 Termination Charges

In making a vehicle available for private use by an individual, the Health Board/Trust does so on the understanding that the user will keep the vehicle for the 3 year contract term. Under certain circumstances the vehicle may become surplus to requirements before the end of the lease and will need to be returned to the leasing company early. In such cases it is normal for leasing companies to make an early termination charge to reflect its increased costs. The Health Board/Trust will recharge the individual with early termination charges if the termination is due to factors within the employee's control. Reasons for early termination and who will pay are as follows:

6.1 The Health Board/*Trust to bear costs in the case of:*

- Ill health retirement.
- Extended Maternity Leave/Adoption Leave
- Redundancy.
- Early retirement for reasons of service efficiency.
- Transfer to duties not requiring/or reduced travelling brought about by management.
- Dismissal
- Organisational Change where the lease Car employee has been forced a change of base which would give them eligibility to excess mileage which if claimed by the employee they will incur additional Benefit In Kind in the form of Fuel Benefit Charge. NWSSP Lease Car Office must be informed directly by the Line Manager.

6.2 User to bear costs in the case of:

- Voluntary resignation of posts for any reason (including new appointment, retirement).
- Retire & Return staff must contact the NWSSP lease Car Department at least 6 months prior to the retirement because if the break in service is longer than 14 days they must return the car on or before the retirement date.
- Voluntary termination/handing back of vehicle before the end of the lease contract.

(**NOTE:** For users who apply internally for a post not requiring travel it is the responsibility of the employee and appointing officer to negotiate arrangements surrounding an existing lease car. These should however be agreed in writing before confirmation of appointment to the new post, by the Director of Workforce and OD, and copied to the NWSSP Lease Car Officer.)

7 Additional Nominated Drivers

The driver can nominate 2 additional drivers which would reside at the principle drivers address holding a full clean driving licence for min of one year over the age of 18 to use the vehicle, where this is a requirement the additional driver will be expected to provide details of their full driving licence and convictions to the NWSSP Lease Car Officer, who will authorise the application. The Health Board/*Trust reserves the right to refuse any such requests.*

8 Return of the Vehicle

8.1 6 months prior to the end of the lease contract, the driver will be contacted by the NWSSP Lease Car Officer to ascertain their intentions with regard to renewal or withdrawal from the scheme.

8.2 The NWSSP Lease Car Officer will advise the driver of the vehicle collection at the end of the lease period. The driver must inspect the car with the collecting agent and any damage must be identified on the inspection form provided, to the satisfaction of the driver and sign for the acceptance of the inspection. Failure to

do so will result in the driver being responsible for any return charges being made by the leasing company. (If you require any further information or advice please contact the NWSSP Lease Car officer prior to collection date) the employee will receive clear instruction via e-mail. The milometer reading must also be entered on the collection sheet and appropriate return vehicle report form supplied by the collecting agent. This will form the basis of the assessment of the drivers/Health Board/Trust liability with regard to claims under the fair wear and tear policy of the leasing company as per the BVRLA so it is vital that the vehicle is returned in a clean and tidy condition.

- 8.3** The employee will be responsible for any charges relating to the Lease Car, these include over contract mileage and end of contract damages, the leasing company invoice the Health Board/Trust for these charges and payment will be deducted from the next pay period. Should this deduction cause financial hardship (must provide evidence) consideration could be given for the cost to be recovered over a reasonable period.
- 8.4** If for whatever reason the employee is dismissed or the contract of employment ended the employee will be required to return the car immediately as part of Health Board/Trust property.

On return of the vehicle the employee only must hand over the vehicle please ensure that identification is sought from the collecting agent before you hand over the car, documentation and keys and a signed termination document is received as a form of receipt from the collector.

9. NHS All Wales Pool Vehicle Policy and Procedure

9.1 Introduction

This document sets out the operational procedures for the application and management of Pool vehicles within the Health Board/Trust. The procedure is relevant to all staff who during the course of their duties for the Health Board/Trust are required to drive a vehicle on behalf of the Health Board/Trust or are responsible for managing a Pool Vehicle within their department.

9.2 Objective

To provide information to all Departmental Pool Vehicle Managers and Pool Vehicle users on the procedures for accessing Pool Vehicles.

9.3. Definitions

- **Departmental Pool Vehicle Manager**- Acting responsible person within the Health Board/Trust department for the allocated Pool Vehicle.
- **Budget Manager/holder** – the manager responsible for the cost of the Pool Vehicle.

- **Pool Vehicle** – a car/van that is Leased by a department manager to enable their staff to carry out their duties. N.B. please refer to the Lease Car policy for lease car arrangements.

10 ROLES / RESPONSIBILITIES

10.1 Head of Department

Each Head of the Department must:

- Ensure all staff read and understand this procedure
- Arrange regular review to monitor compliance with this procedure

10.2 Shared Services, Pool Vehicle Department

To support the respective Health Board/Trust Department Managers in the coordination and administration for applications of new or replacement Pool Vehicles.

NWSSP will source Pool Vehicles via CCS Framework for best value.

Place orders on the respective Health Board/Trust Oracle system from the most cost effective quotation from the Leasing Companies.

10.3 Departmental Pool Vehicle Responsible Manager

To manage the use of allocated Pool Vehicle in accordance with the arrangements detailed in this procedure document.

To carry out driver license authorizing checks, accounting for fuel cards and maintenance.

10.4 Pool Vehicle Users

To use the Pool Vehicle in accordance with the arrangements detailed in this procedure document.

10.5. Monitoring Compliance with the Procedure

Departmental Pool Vehicle responsible managers will monitor and audit Pool Vehicle users adherence to the procedure to ensure log sheets, license checks and fuel receipts are all in compliance.

10.6. Review and Change Control

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice collectively within All Wales Health Board/Trust indicate otherwise.

11. Arrangements for use and Management of Pool Vehicles

11.1 Department Pool Vehicle Request

During the course of carrying out official business, employees of Health Boards/Trust may be required to travel to locations other than their main employment base and the use of a Pool Vehicle may be an economical option for the Department if the following criteria are met:

- a. The provision of a Pool Vehicle provides the most cost effective method of funding the department's business mileage.
- b. The vehicle procured will be a base model and will be dependent on local dealership garage availability in relation to servicing and be the best value for money for the organization.
- c. There will be a dedicated named Departmental Pool Vehicle Manager assigned to take overall responsibility for the Pool Vehicle to ensure drivers fully comply with the standards detailed in this Pool Vehicle procedure document.
- d. All Pool Vehicles will include Standard Safety Packs:- Warning Triangle/Beacon, Din First Aid Kit, Life Hammer, 1kg Fire Extinguisher, Hi-Vis Vest & Mechanical Relief Vehicle.

The Budget Manager will be required to authorize each application and confirm the annual official mileage for the vehicle. Requests will be processed via NWSSP Lease Car Department, who will ensure that the vehicle is the best value for money for Health Board/Trust.

11.2 Conditions of use of a Pool Vehicle

The vehicle will be insured for official business mileage only and must in no circumstances be used for any private mileage.

The Pool car will only be driven by employees of the Health Board/Trust who hold a full driving license.

The Departmental Pool Vehicle Manager will obtain a copy of each driver's current driving license. This will be repeated annually where the employee continues to drive the Pool Vehicle.

The employees must advise the manager of any endorsements on the license.

The Pool vehicle must be kept on Health Board premises overnight. Only in exceptional circumstances and with Executive approval may a vehicle not be kept overnight on its base e.g. to enable staff access to work in the event of a severe weather event. Such instances will be considered business miles for accounting purposes.

Fuel for the vehicle will be obtained via a fuel card issued by the Health Board/Trust through the relevant Departmental Pool Vehicle Manager, and receipts will be attached to the appropriate log sheet in Appendix 4.

Drivers of the Pool vehicle must complete the log sheet for the vehicle and the Departmental Pool Vehicle manager will be required to audit log sheets at the end of each calendar month to verify that the vehicle has been used appropriately and that fuel usage reconciles with mileage driven. These documents should be filed locally for audit.

Please refer to the following HMRC link for further clarification on Pool/Commercial Vehicle guidelines; <https://www.gov.uk/guidance/use-of-company-pooled-cars-or-vans-480-chapter-15>

11.3 Servicing, Maintenance and Repairs

The lease contract includes the full maintenance and servicing in accordance with the manufacturers schedule i.e. repairs, replacement of tyres (through normal wear and tear), replacement vehicles where appropriate, batteries, exhausts etc.

Servicing and repair will be carried out at the nearest available garage approved by the Lease Company and it will be the Departmental Pool Vehicle Managers responsibility to ensure that these take place at appropriate times.

The Departmental Pool Vehicle Manager has a specific responsibility to ensure the following:-

- That the following checks are made on a frequent basis, checking the oil, water, battery, brakes and any other fluid levels, tyre pressures and topping up where required.
- The car is kept in a clean condition.
- There is a strict No Smoking policy and the safe use of Mobile phones which applies to all Pool Vehicle drivers as it does to all other Health Board vehicles.
- Costs for any valeting requirements should be met by Pool Vehicle budget holder where onsite facilities are not available.
- Reporting defects, damage or accidents immediately to the incumbent insurance company.
- Ensure security of the vehicle and keys when not in use.
- Verification of log sheets accuracy, mileage and fuel usage.

- Ensuring that Drivers are aware of any special care that is required when transporting Health Board/Trust property, especially medical supplies and equipment, drugs, mobile phones, computers etc. These items should always be kept out of sight if they must remain in the vehicle.
- Ensuring that drivers are aware that if they fail to report damage or faults with the vehicle that they may be restricted from using the vehicle or in the event of damage may be liable for the cost of the insurance excess for repairs.
- It will be the Departmental Pool Vehicle Managers responsibility for ensuring that the conditions detailed within this procedure are adhered to and to take relevant action where they are not.

11.4 Pool Vehicle Users Undertaking

All staff who are allocated the use of a Pool Vehicle will be required to sign an undertaking accepting liability for the conditions detailed within this procedure.

12. Pool Vehicle Frequently Asked Questions

Q. Can I purchase oil for the Pool Vehicle, using the fuel card provided?

A. YES, you can purchase oil from Fuel stations that stock the correct oil for the vehicle.

Q. If the Pool Vehicle requires Ad-Blue/Screen wash/De-Icer. Where can I get this from?

A. This can be ordered through Oracle as a non-catalogue request or through the local petty cash arrangements against the Pool Vehicle Manager's budget.

Q. Where do I wash the Pool Vehicle? How is it funded?

A. These facilities may be available at the base of the Pool Vehicle (free of charge). If not available you can use a local garage or car wash. Receipts should be provided to enable reimbursement to be made. Reimbursements via petty cash of cleaning expenses of vehicles incurred by staff members is available on some of the main hospital sites where there are petty cash limits of £20.

Q. The Pool Vehicle I was driving has been involved in an accident, what should I do?

A. After ensuring you're own or anyone else's personal safety isn't at risk, assess if any person has sustained any injuries. Determine if and damage is caused to another

vehicle or to someone else's property e.g. street lamps, signs, bollards and other street furniture or any animals/livestock have been injured.

You must then remain at the scene for a reasonable period. Give your vehicle registration number, your name and address, and that of the vehicle owner (if different) to anyone with reasonable grounds for asking for those details if anyone else is involved take the other parties name & address details and also their insurance details and contact the Insurance Company **immediately and within 24 hours** of the accident. **At no time should you admit liability without the advice of the Insurance Company.**

If you don't exchange details at the scene, you must report the accident at a police station or to a police constable as soon as you can, and in any case within 24 hours. All damages to the vehicle must be notified to the Insurance Company immediately.

If another person is injured, you must produce your certificate of insurance, if anyone at the scene has reasonable grounds to see it. If you don't, you must report the accident at a police station or to a constable as soon as you can and in any case within 24 hours.

You'll need to produce your certificate of insurance but if you don't have it when reporting the accident to the police, you may take it, within seven days of the accident, to the police station you nominate when you report the incident. Reporting the accident to the police by telephone isn't sufficient and you can't ask someone else to report for you.

You're obliged to do these things not only when you're directly involved in an accident, but also if your vehicle's 'presence' was a factor.

At the scene, collect and note down as much information as you can including photographs and notes. Useful information includes:-

Scene – date, time, location, weather conditions, traffic conditions, road markings/signs/signals.

Vehicles – make, model, registration number, colour, condition, estimated speed, direction, use of lights or indicators, number of passengers.

People – contact details, description/distinguishing features of driver(s), contact details of passengers, pedestrians or other witnesses, details of any police officers involved.

Damage – description of the damage to vehicles or property, and any injuries to people involved.

Remember to notify the insurance company **immediately** if an accident has occurred.



Appendix 1

NHS All Wales Lease Car Application Form

SELECT THE HEALTH BOARD THAT APPLIES

Swansea Bay ☐ CWM TAF ☐ PHW ☐ POWYS ☐ VELINDRE ☐ HEIW ☐

Select correspondence Language

Welsh/Cymraeg ☐ English ☐

Complete all relevant fields on this form. Ensuring that you have signatures off you the lease car driver, Line manager & Directorate manager. Failure to fully complete this form will prolong the Application process.

SECTION 1 (PERSONAL DETAILS AND MILEAGE ESTIMATE)

<u>TITLE:</u> Mr / Mrs / Miss / Ms / Dr / Prof	<u>FULL NAME:</u>
Payroll No:	Job Title:

<u>HOME ADDRESS:</u>			<u>POST CODE:</u>
<u>WORK ADDRESS:</u>			<u>POST CODE:</u>
<u>WORK TEL NO:</u>	<u>HOME TEL NO:</u>	<u>MOBILE NO:</u>	
<u>NHS EMAIL ADDRESS:</u> Alternative Email address:			
<u>THE EMAIL ADDRESS PROVIDED WILL BE USED TO PROVIDE QUOTATIONS AND COULD INCLUDE PERSONAL AND CONFIDENTIAL INFORMATION. WE RECOMMEND THAT YOU PROVIDE A NHS EMAIL ADDRESS ONLY, PLEASE CHECK YOUR EMAILS ON A REGULAR BASIS.</u> <u>IF YOU WISH TO RECEIVE YOUR QUOTATIONS VIA POST PLEASE TICK THIS</u> <input type="checkbox"/>			

Estimated Business Miles per annum <i>You must not include home to base, excess, redeployment and call out journey (unless to a place other than your base).</i>	
Estimated Private Miles per annum	
Estimated Total Miles per annum <i>Multiples of 1'000 miles <u>ONLY</u></i>	

I wish to apply for a lease vehicle under the terms of the NHS All Wales Lease Car Policy for the selected Health Board. I have read and understood the policy. I confirm that the above information is correct to the best of my knowledge and I confirm my acceptance, in principle, of the Health Board's offer of a lease car for my business and private use and request a quotation of the costs which I will be required to pay via my salary for the vehicles shown below.

Employee's
 Signature: _____ Date: _____

SECTION 2 MANAGER APPROVAL

THE BUSINESS MILEAGE APPLIED FOR IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND INCLUDES ONLY THOSE MILES FOR WHICH TRAVEL EXPENSES WOULD NORMALLY BE PAYABLE (PLEASE ENSURE THAT THE BUSINESS MILEAGE IS AS ACCURATE AS POSSIBLE AS HISTORICAL MILEAGE CHECKS WILL NO LONGER BE UNDERTAKEN BY THE NHS LEASE CAR DEPARTMENT). I CONFIRM THAT THE EMPLOYEE CURRENTLY HOLDS A CONTRACT OF EMPLOYMENT THAT SHALL REMAIN IN FORCE FOR THE PERIOD OF THE 3 YEAR LEASE AND SHOULD THAT CONTRACT END THE CAR MUST BE RETURNED WITH IMMEDIATE EFFECT AS PART OF THE PROPERTY OF THE HEALTH BOARD.

1. Line Manager's Signature: _____

Name (please print):

Email address:

Direct Telephone No:

Date:

2. Directorate Manager's
Signature: _____

Name (please print):

EMAIL ADDRESS:

DIRECT TELEPHONE NO:

Date:

Notes

- Mileage estimates must be as accurate as possible.
- Please note that this form will be returned if the full car specification is not provided.
- A total of only **SIX** vehicle quotations will be provided (ie: a Ford Fiesta in petrol and diesel versions would be classed as two quotes)
- Please also be aware of the options and accessories included with certain makes and models of vehicles. Only list options wanted. If you know that something comes as standard on the vehicle, **DO NOT** list it as an option.
- Limited Edition models offered by some dealerships may not be available to lease.
- The fleet recommendation for CO₂ is 130g/km (reducing to 95 CO₂ emissions in 2020) and the maximum CO₂ figure is 165g/km for all Lease cars.

- Please be aware that diesel engines carry a 4% taxable surcharge. Please be aware that in order to meet environmental legislative requirements many diesel cars are fitted with Diesel Particular Filters (DPFs). If the vehicle you are considering is going to be used predominantly for urban driving, please consult your local dealer.
- ***Standard Safety Packs are in all vehicles and include: Warning Triangle/Beacon, Din First Aid Kit, Life Hammer, 1kg Fire Extinguisher, Hi-Vis Vest & Mechanical Relief Vehicle***

SECTION 3 (VEHICLE CHOICE)

Although every attempt will be made to supply an accurate quotation. The quotation will not be binding & the formal contract will be based on the contractor's rate at the time of receiving the order confirmation.

Vehicle 1

*Delete as appropriate

Make:		
Model:		
Specification:		Manual / Automatic*
Engine size:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Paint finish:	Solid / Special Solid / Metallic / Pearlescent / Other*	
Optional extras required:		

Vehicle 2

Make:		
Model:		
Specification:		Manual / Automatic*

Engine size:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Paint finish:	Solid / Special Solid / Metallic / Pearlescent / Other*	
Optional extras required:		

Vehicle 3

Make:		
Model:		
Specification:		Manual / Automatic*
Engine size:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Paint finish:	Solid / Special Solid / Metallic / Pearlescent / Other*	
Optional extras required:		

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Vehicle 4

Make:		
Model:		
Specification:		Manual / Automatic*
Engine size:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Paint finish:	Solid / Special Solid / Metallic / Pearlescent / Other*	
Optional extras required:		

Vehicle 5

Make:		
Model:		
Specification:		Manual / Automatic*
Engine size:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Paint finish:	Solid / Special Solid / Metallic / Pearlescent / Other*	
Optional extras required:		

Vehicle 6

Make:		
Model:		
Specification:		Manual / Automatic*
Engine size:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/

		Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Paint finish:	Solid / Special Solid / Metallic / Pearlescent / Other*	
Optional extras required:		

Section 4 (Contact Details)

The NHS Lease Car Department is a section of the Payroll Services Department – the postal address is:

NHS Lease Car Department, Matrix House, Northern Boulevard, Matrix Park, Swansea Enterprise Park, Swansea, SA6 8BX.

You can also contact the Team via email at lease.cars@wales.nhs.uk or via telephone on 02920 903908

Some useful information can be found on the Lease Car Intranet Page (navigate through Boardwide Support Services > Payroll Services > Lease Car Department).

Ffurflen Gais Prydlesu Ceir GIG Cymru Gyfan

DEWISWCH Y BWRDD IECHYD SY'N BERTHNASOL

Bwrdd Iechyd Prifysgol Bae Abertawe ☐ CWM TAF ☐ IECHYD CYHOEDDUS CYMRU ☐
 POWYS ☐ FELINDRE ☐ AaGIC ☐

Cwblhewch yr holl feysydd perthnasol ar y ffurflen hon. Sicrhewch eich bod yn cynnwys eich llofnod chi fel gyrrwr y car prydles yn ogystal â llofnodau eich Rheolwr Llinell a Rheolwr y Gyfarwyddiaeth. Bydd methu â chwblhau'r ffurflen hon yn llawn yn ymestyn y broses Ymgeisio.

ADRAN 1 (MANYLION PERSONOL AC AMCANGYFRIF MILLTIROEDD)

TEITL: Mr / Mrs / Miss / Ms / Dr / Yr Athro		ENW LLAWN:	
Rhif Cyflogres:		Teitl Swydd:	
CYFEIRIAD CARTREF:			
COD POST:			
CYFEIRIAD GWAITH:			
COD POST:			
RHIF FFÔN GWAITH:		RHIF FFÔN CARTREF:	
		RHIF FFÔN SYMUDOL:	
CYFEIRIAD E-BOST Y GIG: Cyfeiriad E-bost Arall:			
DEFNYDDIR Y CYFEIRIAD E-BOST A DDARPERIR I DDARPARU DYFYNBRISIAU A GALLENT GYNNWYS GWYBODAETH BERSONOL A CHYFRINACHOL. RYDYM YN ARGYMELL EICH BOD YN DARPARU CYFEIRIAD E-BOST Y GIG YN UNIG. GWIRIWCH EICH E-BYST YN RHEOLAIDD.			
OS YDYCH CHI'N DYMUNO DERBYN EICH DYFYNBRISIAU TRWY'R POST, TICIWCH Y BLWCH <input type="checkbox"/> N			

Amcangyfrif Milltiroedd Busnes y flwyddyn <i>Rhaid i chi beidio â chynnwys milltiroedd o'r cartref i'r gweithle, milltiroedd ychwanegol, adleoli a theithiau galwadau allan (oni bai i le heblaw eich gweithle).</i>	
Amcangyfrif Milltiroedd Preifat y flwyddyn	
Amcangyfrif o Gyfanswm Milltiroedd y flwyddyn <i>Lluosrifau o 1'000 o filltiroedd YN UNIG</i>	

Hoffwn wneud cais am gerbyd prydles o dan delerau Polisi Prydlesu Ceir GIG Cymru ar gyfer y Bwrdd Iechyd a ddewiswyd. Rwyf wedi darllen ac yn deall y polisi. Rwyf yn cadarnhau bod yr wybodaeth uchod yn gywir hyd eithaf fy ngwybodaeth ac rwyf yn cadarnhau fy mod yn derbyn, mewn egwyddor,

gynnig y Bwrdd Iechyd o gar prydles ar gyfer fy nefnydd busnes a phreifat. Rwyf yn gofyn am ddyfynbris o'r costau y bydd rhaid i mi eu talu trwy fy nghyflog am y cerbydau a ddangosir isod.

Llofnod y
Gweithiwr: _____ Dyddiad: _____

ADRAN 2 CYMERADWYAETH Y RHEOLWR

MAE'R MILLTIROEDD BUSNES Y GWNAED CAIS AMDANYNT YN GYWIR HYD EITHAF FY NGWYBODAETH AC YN CYNNWYS DIM OND Y MILLTIROEDD HYNNY Y BYDDAI COSTAU TEITHIO FEL ARFER YN DALADWY AMDANYNT (GWNEWCH YN SIŴR BOD Y MILLTIROEDD BUSNES MOR GYWIR Â PHOSIBL GAN NA FYDD ADRAN CAR PRYDLES Y GIG YN CYNNAL GWIRIADAU MILLTIROEDD HANESYDDOL MWYACH). RWYF YN CADARNHAU BOD GAN Y GWEITHIWR GONTRACT CYFLOGAETH AR HYN O BRYD A FYDD YN PARHAU YN WEITHREDOL AM GYFNOD 3 BLYNEDD Y BRYDLES AC OS BYDD Y CONTRACT HWNNW'N DOD I BEN, BYDD RHAID DYCHWEL YD Y CAR AR UNWAITH FEL RHAN O EIDDO'R BWRDD IECHYD.

1. Llofnod y Rheolwr Llinell:

Enw (ysgrifennwch mewn priflythrennau):

Cyfeiriad E-bost:

Rhif Ffôn Uniongyrchol:

Dyddiad:

—

2. Llofnod Rheolwr y

Gyfarwyddiaeth: _____

Enw (ysgrifennwch mewn priflythrennau):

CYFEIRIAD E-BOST:

RHIF FFÔN UNIONGYRCHOL:

Dyddiad:

—

Nodiadau

- Rhaid i amcangyfrifon milltiroedd fod mor gywir â phosibl.
- Sylwch y dychwelir y ffurflen hon os na ddarperir manyleb lawn y car.
- Darperir cyfanswm o **CHWE** dyfynbris cerbyd (h.y: byddai Ford Fiesta petrol a diesel yn cael ei ystyried yn ddau ddyfynbris)
- Byddwch yn ymwybodol hefyd o'r opsiynau a'r ategolion sydd wedi'u cynnwys gyda rhai gwneuthuriadau a modelau o gerbydau. Rhestrwch yr opsiynau rydych eu heisiau yn unig. Os ydych chi'n gwybod bod rhywbeth yn dod gyda'r cerbyd fel rhywbeth safonol, PEIDIWCH â'i restru fel opsiwn.
- Efallai na fydd modelau cyfyngedig a gynigir gan rai delwriaethau ar gael i'w prydlesu.
- Argymhelliad y fflyd ar gyfer CO₂ yw 130g/km a'r ffigur CO₂ uchaf yw 165g/km ar gyfer pob car Prydles.
- Byddwch yn ymwybodol bod gordal trethadwy o 4% ar beiriannau diesel. Er mwyn cwrdd â gofynion deddfwriaethol amgylcheddol, cofiwch fod Hidlyddion Gronynnau Diesel wedi'u gosod mewn llawer o geir diesel. Os yw'r cerbyd rydych chi'n ei ystyried yn mynd i gael ei ddefnyddio'n bennaf ar gyfer gyrru trefol, ymgynghorwch â'ch deliwr lleol.

ADRAN 3 (DEWIS CERBYD)

Er y gwneir pob ymdrech i ddarparu dyfynbris cywir, ni fydd y dyfynbris yn rhwymol a bydd y contract ffurfiol yn seiliedig ar gyfradd y contractwr ar adeg derbyn cadarnhad yr archeb.

Cerbyd 1

***Dileu fel sy'n briodol**

Gwneuthuriad:		
Model:		
Manyleb:		Geriau llaw / Awtomatig*
Maint y peiriant:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
Nifer y Drysau:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Gorffeniad paent:	Solid / Special Solid / Metallic / Pearlescent / Arall*	
Pethau ychwanegol dewisol sydd eu hangen:		

Cerbyd 2

Gwneuthuriad:	
---------------	--

Model:		
Manyleb:		Geriau llaw / Awtomatig*
Maint y peiriant:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
Nifer y Drysau:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Gorffeniad paent:	Solid / Special Solid / Metallic / Pearlescent / Arall*	
Pethau ychwanegol dewisol sydd eu hangen:		

Cerbyd 3

Gwneuthuriad:		
Model:		
Manyleb:		Geriau llaw / Awtomatig*

Maint y peiriant:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
Nifer y Drysau:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Gorffeniad paent:	Solid / Special Solid / Metallic / Pearlescent / Arall*	
Pethau ychwanegol dewisol sydd eu hangen:		

Cerbyd 4

Gwneuthuriad:		
Model:		
Manyleb:		Geriau llaw / Awtomatig*
Maint y peiriant:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
Nifer y Drysau:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	

Gorffeniad paent:	Solid / Special Solid / Metallic / Pearlescent / Arall*
Pethau ychwanegol dewisol sydd eu hangen:	

Cerbyd 5

Gwneuthuriad:		
Model:		
Manyleb:		Geriau llaw / Awtomatig*
Maint y peiriant:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
Nifer y Drysau:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Gorffeniad paent:	Solid / Special Solid / Metallic / Pearlescent / Arall*	

Pethau ychwanegol dewisol sydd eu hangen:	
--	--

Cerbyd 6

Gwneuthuriad:		
Model:		
Manyleb:		Geriau llaw / Awtomatig*
Maint y peiriant:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
Nifer y Drysau:	2dr / 3dr Hatch / 5dr Hatch / 4dr Saloon / 5dr Estate / Cabriolet / Coupe*	
Gorffeniad paent:	Solid / Special Solid / Metallic / Pearlescent / Arall*	
Pethau ychwanegol dewisol sydd eu hangen:		

Adran 4 (Manylion Cyswilt)

Mae Adran Prydlesu Ceir y GIG yn rhan o'r Adran Gwasanaethau Cyflogres - y cyfeiriad post yw:

Adran Car Prydles y GIG, Tŷ Matrix, Boulevard y Gogledd, Parc Matrix, Parc Anturiaeth Abertawe, Abertawe, SA6 8BX.

Gallwch hefyd gysylltu â'r Tîm trwy anfon [e-bost at lease.cars@wales.nhs.uk](mailto:e-bost.at.lease.cars@wales.nhs.uk) neu drwy ffonio 02920 903908

Gellir dod o hyd i wybodaeth ddefnyddiol ar y Dudalen Mewnwyd Prydlesu Ceir (llywioch Boardwide Support Services > Payroll Services > Lease Car Department).

Appendix 2



NHS All Wales Lease Car Order Form

NB: Please complete all sections fully. Failure to comply will result in delay of Car Order.

Section 1 (Personal Details and Mileage Estimate)

<u>FULL NAME:</u>		<u>PAYROLL No:</u>
<u>HEALTH BOARD/TRUST: *DELETE AS APPROPRIATE</u> SBU LHB / CTM HB / PHW / PTLHB / VELINDRE NHS TRUST		
<u>JOB TITLE:</u>		
<u>HOME ADDRESS:</u>		
<u>POST CODE:</u>	<u>PLEASE TICK IF THIS IS YOUR PREFERRED DELIVERY ADDRESS</u> <input type="checkbox"/>	
<u>WORK ADDRESS:</u>		
<u>POST CODE:</u>	<u>PLEASE TICK IF THIS IS YOUR PREFERRED DELIVERY ADDRESS</u> <input type="checkbox"/>	
<u>* NHS E-MAIL ADDRESS ONLY:</u>	<u>TEL No (INC CODE):</u>	<u>MOBILE No:</u>
<u>ANNUAL MILEAGE AS PER QUOTATION:</u>		
<u>BUSINESS MILES:</u>	<u>PRIVATE MILES:</u>	<u>TOTAL MILES:</u>

* I confirm that I have provided an NHS email address that I agree to receive personal and confidential information through. Please check your emails on a regular basis for updates on your lease car order.

Section 2 (Vehicle Required)

1. Car description:- Manufacturer / Model / Specification / Engine Size	
2. Fuel Type (please select):	Petrol / Diesel / Hybrid / Other

3. No of doors (please select):	2dr / 3dr hatch / 4dr saloon / 5dr hatch / 5dr estate
4. Extra options (if applicable and included on your quotation letter):	
5. Exterior Colour Choice: 1st: 2nd: Please ensure you provide us with the correct colour name (e.g. satin silver); we cannot accept 'any colour'. You must only provide a colour choice within the paint finish which you have been quoted. <i>Only state a colour which you are happy to accept, you do not have to provide a second colour choice if not required, the lease company may chose the colour with the quickest availability.</i>	
6. Interior Choice: (If left blank the manufacturers standard interior will be provided)	
Monthly Rental: £ <i>shown on quotation</i>	

Section 3 (Nominated Drivers and Licences)

Please see Lease Car Policy for restrictions

Principle driver name*:	Licence no:
Additional driver name:	Licence no:
Relationship to applicant:	D.O.B:

You must provide a copy of the full current driving licences for the two people named above – for new style licences you must include the photo card (front & back) and new ONLINE summary (obtained via DVLA online: www.gov.uk/check-driving-information). Your order will not be processed if you fail to supply the driving licences at this stage, or give a valid reason for their omission.

* I understand that I will not be able to take possession of the vehicle unless I have provided a copy of the principal driver's licence as detailed above (an additional driver will not be authorised or insured to drive until the full licence is provided). If licences are unavailable immediately then please state reason here:

Section 4 (Health Declaration)

The law requires you to tell the DVLA about any condition that may affect your ability to drive safely. If you are involved in an accident and it is found that your health condition was a contributing factor, you may be prosecuted and your insurance may not be valid. In line with the DVLA Medical Standards of Fitness to Drive, you and your nominated driver have a duty to disclose any of the following disorders / illnesses to the DVLA.

Neurological disorders Cardiovascular disorders Diabetes mellitus Psychiatric disorders / cognitive function impairment Drug and alcohol misuse/dependency Visual disorders Deafness disorders Renal disorders Respiratory disorders Sleep disorders Brain tumours Lung or other cancers Hiv positive or aids syndrome	<p>Taking this disclosure requirement into consideration, are you and your nominated driver 'fit to drive'?</p> <table border="1"><tr><td>Yes</td></tr><tr><td>No</td></tr></table> <p>(If you have answered 'no' to the above question could you please ring the NHS lease car department immediately and in absolute confidence on: 01792 5321 28/29/30)</p>	Yes	No
Yes			
No			

Section 5 (Insurance History)

Please give details of any motor insurance application refusals and/or special items imposed and/or motor policies cancelled for any person detailed above. Use separate sheet if necessary.

Name of Driver	Details

Section 6 (Employee Declaration)

I have read and understood the All Wales NHS Lease Car Policy and hereby declare that I agree to fully observe all its requirements. I authorise the relevant deductions from my salary for private use. I confirm that the information given by me is correct to the best of my knowledge. *Should I wish to cancel my order before the vehicle has been delivered I authorise NWSSP to deduct any cancellation charge levied by the leasing company from my pay.*

I agree to fully familiarise myself with the controls of my chosen vehicle prior to delivery. The delivery agent is not responsible for any instructions.

Should I leave the Health Board for any reason before the end of the lease period I understand that my liability for termination charges will be governed by the provisions of the policy and I will be required to hand back the vehicle with immediate effect.

Employee _____ Signature: _____
Date: _____

SECTION 7 (LINE MANAGER AUTHORISATION)

Line Manager's Signature: _____
Date: _____

Line Manager's Full Name: _____
Tel: _____

EMAIL

ADDRESS: _____

Please return completed order form with full copies of driving licences to:

Email: lease.cars@wales.nhs.uk

WHERE POSSIBLE PLEASE SEND AN ORIGINAL, AUTHORISED COPY OF THIS FORM.

COPIES MAY BE SENT VIA EMAIL BUT WILL ONLY BE ACCEPTED FROM THE AUTHORISING MANAGER.

Office Use Only

Requisition Number:	Dir Finance Code:
Leasing Company:	Annual Rental:

Processed in Oracle by:	Approved by:
Signed:	Signed:
Date:	Date:

Appendix 3

NHS All Wales Pool Vehicle Application Request

I wish to make an application for a Pool vehicle under the terms of the Department Pool Operational Procedure. I have read and understood the procedure and if I accept a quotation, I understand that I shall be bound to keep the vehicle for the term of lease. I also undertake to ensure that the vehicle will be properly maintained in line with the manufacturer requirements.

For the purpose of a Pool vehicle I understand that the specification of the vehicle is restricted to that of a base vehicle with no additional options and will be further restricted with dealerships that are convenient for services. The vehicle offered will be the best value for money for Health Board/Trust.

I have discussed the future business mileage with the Executive Director for the department, these are believed to be the realistic mileage for this vehicle and we know of no reason why this should change in the immediate future.

The Business miles for this vehicle are estimated to be Miles per annum.

I attach the request for quotations for a vehicle (Appendix 7) on the basis of the mileage shown above and understand that the vehicle recommended by the NWSSP Lease Car Department, to be the most cost effective option following a costing exercise to ensure value for money.

I understand and accept the responsibilities of a Pool Car Manager and that I will be responsible for the following:-

- Ensuring that the vehicle Driver is an employee of the Health Board/Trust and has a current Full Driving License.

-
- Verifying vehicle users licenses before use and annually thereafter.
 - Ensuring that the vehicle is maintained and kept in a roadworthy condition.
 - Ensuring that all Pool Vehicles will include Standard Safety Packs:- Warning Triangle/Beacon, Din First Aid Kit, Life Hammer, 1kg Fire Extinguisher, Hi-Vis Vest & Mechanical Relief Vehicle.
 - Ensuring that the vehicle is kept on Health Board/Trust premises overnight.
 - Ensuring that the log sheets and receipts for fuel are completed for each journey and receipts attached where applicable for fuel.
 - That the vehicle is kept in a clean condition.
 - The security of the vehicle keys when not in use.
 - That all faults or accidents are reported immediately.
 - That the servicing of the vehicle, replacement of tyres, etc. are carried out when required.
 - That the business mileage of the vehicle is monitored and any increase or decrease in the estimated mileage is notified to the NWSSP Lease Car Department, on an annual basis.
 - Any fixed penalty offences/Parking fines/congestion charges & speeding fines are the personal responsibility of the named driver of the vehicle at the time the fine was issued.
All fines will incur an administration charge both from the Leasing Company and the Lease Car Team.
 - There is a NO smoking and Safe Use of Mobile Phones policy in all Health Board/Trust vehicles.
 - Disciplinary action may be carried out against a driver or the departmental manager responsible for the Pool vehicle if any of the above points are not carried out strictly in accordance with this procedure.

Applicant Details

(If applicable) please provide the registration of previous/old Pool Vehicle Reg:

Name of the Budget Manager:
Job Title:
Department:
Pool Vehicle Manger:
Address:
.....
Work Tel:
Mobile No:
Email Address:

- Drivers of the car will be required to enable a DVLA license check by the respective Pool Vehicle Manager, before they are allowed to use the vehicle.

Employee Declaration

I have read and fully understood the procedure

Name (print):.....

Signature:.....

Date:.....

Pool Vehicle Managers Authorisation

I have read and understood the procedure, in particular my responsibilities as the Budget Manager of a Pool Vehicle. The business mileage applied for is accurate to the best of my knowledge and includes only those miles for which travel expenses would normally be payable.

I can confirm that all employees who will have use of the vehicle currently hold a contract of employment with Health Board/Trust and a current full driving license.

Pool Vehicle Managers signature:

Name (please print):

Position:

Budget Code for Charge:

Date:

Executive Director Approval:

Director Signature:

Name (please print):

Date:

Appendix 4

Daily Safety Checks and Weekly Fuel Usage Records

Vehicle Registration _____ Week Ending _____

The Following Items Must Be Checked Prior To Driving This Vehicle

"NIL" should be entered to indicate no defects – do not just tick box.
Any defect must be reported immediately to your Pool Vehicle Manager
and the vehicle should not be used until the fault is rectified.

Please note: it is the responsibility of anyone using this vehicle to check
its roadworthiness and complete this sheet prior to driving, refuel it and
clean it after use.

When leaving the vehicle unattended the driver must ensure the keys
are removed and that the vehicle and its contents are secured.

All staff are to ensure that when any vehicle is in their care, it is either
parked or stopped for any unloading/loading that both the engine and
radio are switched off.

Mileage Start of week _____ Mileage end of week _____

Day/Date	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Battery							
Fuel & Supply & Card							
Oil & Brake Fluid Levels							
Radiator Level							
Screen Wash							
Wiper Blades							
Head & Side Lights							
Brake & Fog Lights							
Indicators & Reflectors							
Tyres & Wheel security							
Mirrors							
Brakes							
Bodywork							
Horn							

Appendix 5

Safety Flash Card - to be kept in vehicle

FLASHCARD FOR DRIVING AT WORK

Reference: Risk Assessment Issued: 20 sept 2018

DO NOT use any equipment unless you have been trained in its safe use and operation and have been given permission



PRE-OPERATIONAL SAFETY CHECKS:

- ✓ Conduct Daily Vehicle Check/Sheet **before leaving**
- ✓ Report any defects or damage to the departmental fleet car manager **before leaving**
- ✓ Complete Vehicle Log Book (pre & post shift)
- ✓ Vehicle must be clean inside & out
- ✓ Ensure Annual Driver License check has been Submitted
- ✓ Plan your route - **before leaving**
- ✓ Wear Safety Belts **at all times**
- ✓ Ensure all loads are secure - **before leaving**
- ✗ **Do not** use mobile devices whilst driving
- ✗ **Smoking, Eating & Drinking** in the vehicle is prohibited

DRIVING:

- ✓ **ALWAYS** adhere to Road Traffic Law and the Highway Code or any other relevant signage at all times
- ✓ **BE** considerate to other road users at all times
- ✓ **Comply and Report** any warning lights presented on your Instrument Panel
- ✓ **Only** drive within area of own competence **ALWAYS** park safely and as directed by signage etc.
- ✓ **MINIMISE** reversing wherever possible
- ✗ **Do not** make or receive any calls in the absence of a Hands-free System
- ✗ **Do not** attempt to drive if unwell or impaired or influenced by alcohol
- ✓ **ALWAYS** inform your Manager of any concerns

BREAKDOWNS & INCIDENTS:

- ✓ **STOP** in a safe position and switch off engine **If safe**, leave vehicle and go to a place of safety
- ✓ **WEAR** High Visibility Clothing & PPE **CONTACT** Lease company and report event immediately

In the event of an accident contact 999 (if necessary)

Switch off engine and remove keys from the ignition (if safe)

- ✗ **Do not** move the injured unless it is safe to do so
- ✗ **Do not** move vehicle unless it is safe or necessary to do so

- ✗ **Do not** put yourself or others in danger **EXCHANGE** all details i.e. name, contact number **before leaving**
- COMPLETE** an Internal **Datix** report when returning to base

TEAM LEADER/MANAGER ACTIONS:

- ✓ **CONDUCT** frequent vehicle spot checks for DVI and cleanliness.

VEHICLE SERVICING:

All vehicles must be fully serviced, **MOT'd** and hold valid Tax

Transport Manager shall hold records of all inspections, safety checks etc.

REPORT all defects as soon as possible **ALWAYS** check that defects have been rectified

Pool Vehicle Log Sheet

Vehicle Base

[illegible]

Certification of Pool Department Vehicle Manager – I hereby certify that the official mileages recorded were in respect of journeys on official business and necessary.

Signature

Date _____

Issue Date:
Status:

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Review Date: October 2019
Approved By:



APPENDIX 7

NHS All Wales Pool/Commercial Vehicle Application Form

Select correspondence Language

Welsh/Cymraeg ☐ English ☐

Please complete details of the vehicle required, and forward to your Directorate/Clinical Manager for authorisation prior to submission to the Lease Car Department. A quotation based on the information provided and current hire charges will be forwarded to you as soon as it becomes available. Although every attempt will be made to supply an accurate quotation, the quotation will not be binding, and the formal contract will be based on the contractor's rates at the time of receiving the order confirmation.

SECTION 1 (HEALTH BOARD / TRUST DETAILS AND MILEAGE ESTIMATE)

<u>HEALTH BOARD/TRUST:</u>	<u>DEPARTMENT</u>
Contact Name :	Job Title :
<u>WORK ADDRESS:</u>	
<u>POST CODE:</u>	
<u>WORK TEL No:</u>	
<u>NHS EMAIL ADDRESS:</u>	

Estimated Business Miles per annum	
------------------------------------	--

SECTION 2 MANAGER APPROVAL

I confirm that the above information is correct and to the best of my knowledge for a department pool/commercial vehicle for business use only.

THE BUSINESS MILEAGE APPLIED FOR IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I CAN CONFIRM THAT THE CONTRACT SHALL REMAIN IN FORCE FOR THE PERIOD OF THE 3 YEAR LEASE AND SHOULD THAT CONTRACT END, THE DEPARTMENT CAR MUST BE RETURNED WITH IMMEDIATE EFFECT AS PART OF THE PROPERTY OF THE HEALTH BOARD/TRUST.

1. Line Manager's Signature:

Name (please print):

Email address:

Direct Telephone No:

Date:

SECTION 3 (VEHICLE CHOICE)

Although every attempt will be made to supply an accurate quotation. The quotation will not be binding & the formal contract will be based on the contractor's rate at the time of receiving the order confirmation.

Standard Safety Packs on all vehicles include: Warning Triangle/Beacon, Din First Aid Kit, Life Hammer, 1kg Fire Extinguisher, Hi-Vis Vest & Mechanical Relief Vehicle

Vehicle 1

Make:		
Model: Body Style: Cabs: <u>Commercial Only</u> No Seats:		
Specification:		Manual / Automatic
Engine size: Drive: Eg: 2WD/4WD		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors: Type of Doors: <u>(Commercial Only)</u>		
Paint finish & Colour:		
Optional extras required:		

Vehicle 2

Make:		
Model: Body Style: Cabs: <u>(Commercial Only)</u> No Seats:		
Specification:		Manual / Automatic
Engine size: Drive: Eg: 2WD/4WD		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/ Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors: Type of Doors: <u>(Commercial Only)</u>		
Paint finish & Colour:		
Optional extras required:		

Vehicle 3

Make:		
Model: Body Style: Cabs: <u>(Commercial Only)</u> No Seats:		
Specification:		Manual / Automatic

Engine size:		Diesel/ Diesel-Electric Hybrid/ Diesel Plugin electric Hybrid/ Electric/ Hydrogen Fuel cell/
Drive: Eg: 2WD/4WD		Petrol/ Petrol-Electric Hybrid/ Petrol Plugin electric Hybrid
No. of Doors:		
Type of Doors: (Commercial Only)		
Paint finish & Colour:		
Optional extras required:		

Section 4 (Contact Details)

The NHS Lease Car Department is a section of the Payroll Services Department.

You can also contact the Team via email at lease.cars@wales.nhs.uk or via telephone on 02920 903908

Appendix 8

NHS All Wales Pool/Commercial Vehicle Order Form

NB: Please complete all sections fully. Failure to comply will result in delay of car order.

Section 1 (Department Details and Mileage Estimate)

<u>DEPARTMENT:</u>		
<u>ANNUAL BUSINESS MILEAGE:</u>		
<u>WORK ADDRESS:</u>		
<u>EMAIL ADRESS</u>	<u>EXT NUMBER</u>	<u>DEPARTMENT COST CODE</u>
<u>CONTACT NAME</u>		

. Please check your emails on a regular basis for updates on your DEPARTMENT Pool Vehicle order.

Section 2 (Vehicle Required)

7. Car description:- Manufacturer/ Model / Specification / Engine Size Cabs: (Commercial Only)	
8. Fuel Type (please select):	Petrol / Diesel / Hybrid / Other
9. No of doors (please select): Type of Doors: (Commercial Only)	5dr hatch / 5dr estate /Van
10. Extra options (if applicable and included on your quotation letter):	
11. Exterior Colour Choice: Please ensure you provide us with the correct colour name (e.g. satin silver); we cannot accept 'any colour'. You must only provide a colour choice within the paint finish which you have been quoted. <i>Only state a colour which you are happy to accept, you do not have to provide a second colour choice if not required, the lease company may chose the colour with the quickest availability.</i>	
12. Interior Choice: (If left blank the manufacturers standard interior will be provided)	
Annual Cost : £	

<i>shown on quotation</i>	
Financial Code : <i>shown on quotation</i>	

To meet HMRC regulations for pool vehicles, the following conditions must be met:-

- **Vehicle is used for official business use only and under no circumstances should the vehicle be used for personal use.**
- **Used by more than one employee.**
- **Drivers are not permitted to take pool vehicles home.**

Department pool/commercial vehicles must be returned to base after use. Where this is out of normal working hours, arrangements must be made for keys to be safely deposited. Failing this will incur a Tax liability.

SECTION 3 (DIRECTORATE MANAGER AUTHORISATION)

Directorate Manager's Signature: _____

Date: _____

Directorate Manager's Full Name: _____

Tel: _____

Please return completed order form by Email: lease.cars@wales.nhs.uk or post to:

All Wales NHS Lease Car Department, Matrix House, Northern Boulevard, Matrix Park, Swansea Enterprise Park, Swansea, SA6 8BX.

WHERE POSSIBLE PLEASE SEND AN ORIGINAL, AUTHORISED COPY OF THIS FORM. COPIES MAY BE SENT VIA EMAIL BUT WILL ONLY BE ACCEPTED FROM THE AUTHORISING MANAGER.

Office Use Only

Requisition Number:	
Leasing Company:	Annual Rental:

Processed in Oracle by:	Approved by:
Signed:	Signed:
Date:	Date:

Trust Board Part A

AMENDMENT TO STANDING ORDERS

DATE OF MEETING	26/11/2020
------------------------	------------

PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not applicable – Public
--	-------------------------

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Director of Corporate Governance

REPORT PURPOSE	FOR APPROVAL
-----------------------	--------------

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Not Applicable	~	~

ACRONYMS	
SO ToR	Standing Orders Terms of Reference

1. SITUATION

- 1.1 The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.
- 1.2 All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.
- 1.3 The purpose of this report is to outline the required changes to the Trust Standing Orders resulting from the establishment of the new Board Committee model.

The Board is asked to **APPROVE** the revised Standing Orders for the new & revised Terms of Reference and operating arrangements.

2. BACKGROUND

- 2.1 In September 2020, the Trust Board approved a new Board Committee model resulting in the move from a top line nine-committee model to a five-committee model as outlined in Appendix 1.
- 2.2 The new Board Committee model introduces a host of key changes to the operating arrangements including the establishment of two new committees, namely the Quality, Safety and Performance Committee and the Strategic Development Committee. In parallel, it invokes the dissolution of the Quality & Safety Committee, Planning & Performance Committee, Digital & Information Governance Committee and Workforce & Organisational Development Committee, which will no longer operate as separate committees.
- 2.3 The revised Board Committee model has necessitated a review of all Board Committee Terms of Reference and operating arrangements together with the development of new Terms of Reference for the Quality, Safety and Performance Committee and the Strategic Development Committee.
- 2.4 The Trust Board Committees have been asked to endorse the new/revised Terms of Reference at their first meeting and the Trust Board Audit Committee has endorsed the proposed amendments for the Board's consideration.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The Standing Orders appended Schedule 3.0 has been included in entirety at Appendix 2, and includes the following key changes:

- Inclusion of Terms of Reference for the new Quality, Safety and Performance Committee and the Strategic Development Committee which have been developed to support the implementation of these meetings.
- All other Committee Terms of Reference have been reviewed for consistency to reflect the new Board Committee model and any amendments identified in **red and scored through** for ease of reference.

3.2 Publication of revised Standing Orders

If approved the Standing Orders will be uploaded to both the Trust Intranet and Internet sites.

3.3 The Standing Orders will be further strengthened in year to reflect the outcomes of the mapping of the Trust's accountability for hosted organisations to the revised Committee Structure and associated oversight and assurance mechanisms.

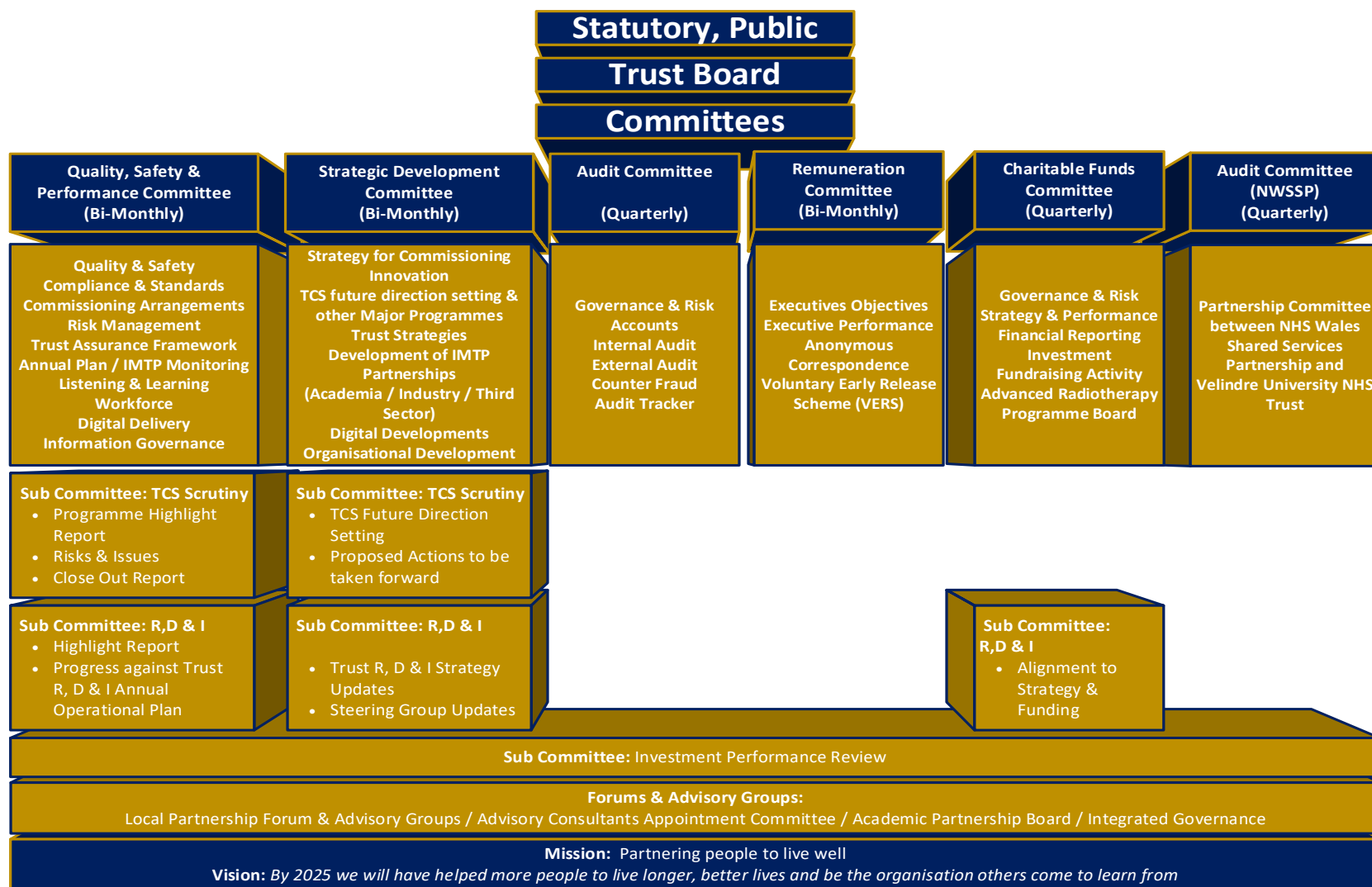
4. IMPACT ASSESSMENT

	Yes (Please see detail below)
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Evidence suggests there is a correlation between governance behaviours in an organisation and the level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	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 Board is asked to **APPROVE** the amendments to the Trust Board Standing Orders as outlined in section 2 of this report.

APPENDIX 1 – TRUST GOVERNANCE & ACCOUNTABILITY FRAMEWORK



SCHEDULE 3

BOARD COMMITTEE ARRANGEMENTS

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

Terms of Reference and Operating Arrangements for the:

- ~~Quality, Safety & Performance Committee~~
- ~~Strategic Development Committee~~
- Audit Committee
- Charitable Funds Committee
- Remuneration Committee
- Transforming Cancer Services Programme Scrutiny ~~Sub-Committee~~
- Research, Development & Innovation ~~Sub-Committee~~
- ~~Information Governance and IM&T Committee~~
- ~~Planning & Performance Management Committee~~
- ~~Quality & Safety Committee~~
- ~~Workforce & Organisational Development Committee~~

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9. Planning & Performance Management Committee Terms of Reference & Operating Arrangements	
10. Quality & Safety Committee Terms of Reference & Operating Arrangements	
11. Workforce & Organisational Development Committee	

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Developed:	November 2020
Approved:	
Next Review Due:	October 2021

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".
- 1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee**. The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

- 2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:
- Evidence based and timely **advice** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the:
 - quality, safety and performance of healthcare;
 - all aspects of workforce;
 - digital delivery and information governance; and
 - **Assurance** to the Board in relation to the Trust's arrangements for safeguarding and improving the quality, safety and performance of patient and service user centred healthcare, workforce matters, digital delivery and information governance in accordance with its stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** to the Board:

- Consider the implications for quality, safety, performance, workforce, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board.
- Consider the implications for the Trust's quality, safety, performance, workforce, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators.
- Monitor progress against the Trust's Integrated Medium Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board.
- Advise the Board on aligning Service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities.
- Monitor progress against cost improvement programmes.
- Ensure that appropriate systems are in place to develop and approve all Business Cases above Chief Executive's authorised limits in line with agreed policy.
- Provide initial scrutiny of all business cases above Chief Executive's authorised limits.
- Monitor & review the Trust's Capital Programme Expenditure.
- Ensure a system is in place and running effectively to prioritise schemes from the Trust Capital Programme.
- Monitor and review performance against the Trust's Assurance Framework.
- Ensure areas of significant service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation.
- Monitor outcomes/outputs from service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery.

3.2 The Committee will, in respect of its assurance role, seek assurances that governance, including risk management arrangements, are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities.

3.3 To achieve this, the **Committee's programme of work** has been designed to ensure that, in relation to all aspects of quality, safety, performance, workforce, digital and information governance:

- Ensure that the Trust Policies, Procedures and Strategies consistent with internal and external requirements are implemented as appropriate.
- The organisation, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor safety and safeguarding above all other considerations;
- The care and services planned or provided across the breadth of the organisation's functions (including divisional/team and those provided by the independent or third sector) is consistently applied, based on sound evidence, clinically effective and meeting agreed standards;
- The organisation, at all levels (divisional/team) has the right systems and processes in place to deliver, from a patient or donor perspective - efficient, effective, timely and safe services;
- The workforce is appropriately selected, trained, supported and responsive to the needs of the Service, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- There is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);
- The integrity of data and information is protected, ensuring valid, accurate, complete and timely data and information is available to support decision making across the organisation;
- There is an ethos of continual quality improvement and a safety culture that supports safe high quality care prevails;
- There is good team working, collaboration and partnership working to provide the best possible outcomes for citizens;
- Risks are actively identified and robustly managed at all levels of the organisation;
- Decisions are based upon valid, accurate, complete and timely data and information;
- The Standards for Health Services in Wales are used to monitor and improve standards across the whole organisation;
- All reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:
 - sources of internal assurance are reliable
 - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
 - lessons are learned from concerns, incidents, complaints and claims.
- There is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board.

3.4 The Committee will advise the Board about key indicators of quality, safety and performance, which will be reflected in the organisations performance framework, against which the Trust's performance will be regularly assessed and reported on through Annual Reports.

Authority

3.5 The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- Any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.

- Obtain legal or other providers of independent professional advice, and to secure the attendance of individuals external to the organisation who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Organisation at any meeting of the Committee.

3.6 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.7 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

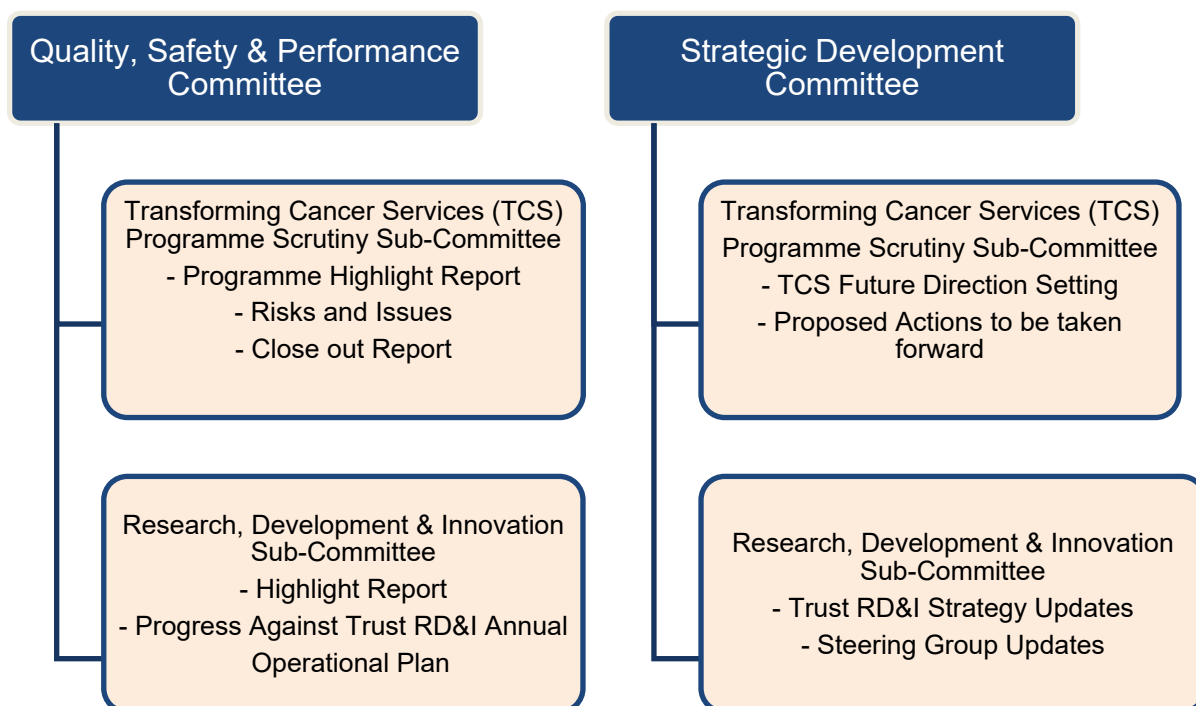
Sub Committees

3.8 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted by the Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

MEMBERSHIP

Members

3.9 A minimum of two (2) members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
	One independent member of the Board (Non-Executive Directors)
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

3.10 Attendees:

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director (*also Caldicott Guardian*)
- Chief Operating Officer
- Divisional Directors from WBS and VCC
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance
- Executive Director of Finance (*also Information Governance*)
- Executive Director of Organisational Development and Workforce
- Director of Strategic, Transformation, Estates, Planning & Digital
- Deputy Director of Nursing Quality & Patient Experience
- Associate Director of Digital (*also cyber/data outtages/performance*)
- Quality & Safety Manager
- Claims Manager
- Head of Corporate Governance

3.11 By invitation

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.

The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Wales Audit Office
- Trade Unions
- Community Health Council

Secretariat

3.12 Secretary - as determined by the Director of Corporate Governance

Member Appointments

3.13 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

- 3.14 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

- 3.15 The Director of Corporate Governance, on behalf of the Committee Chair, shall:
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
 - Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce

4. COMMITTEE MEETINGS

Quorum

- 4.1 At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

- 4.2 Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Committee deems necessary.

Withdrawal of individuals in attendance

- 4.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

- 5.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.
- 5.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 5.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:
- joint planning and co-ordination of Board and Committee business; and
 - sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

- 5.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.
- 5.5 The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes verbal updates on activity, the submission of Committee Highlight Reports and other written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;
- Bring to the Board's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Trust.

6.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

7. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

7.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee.

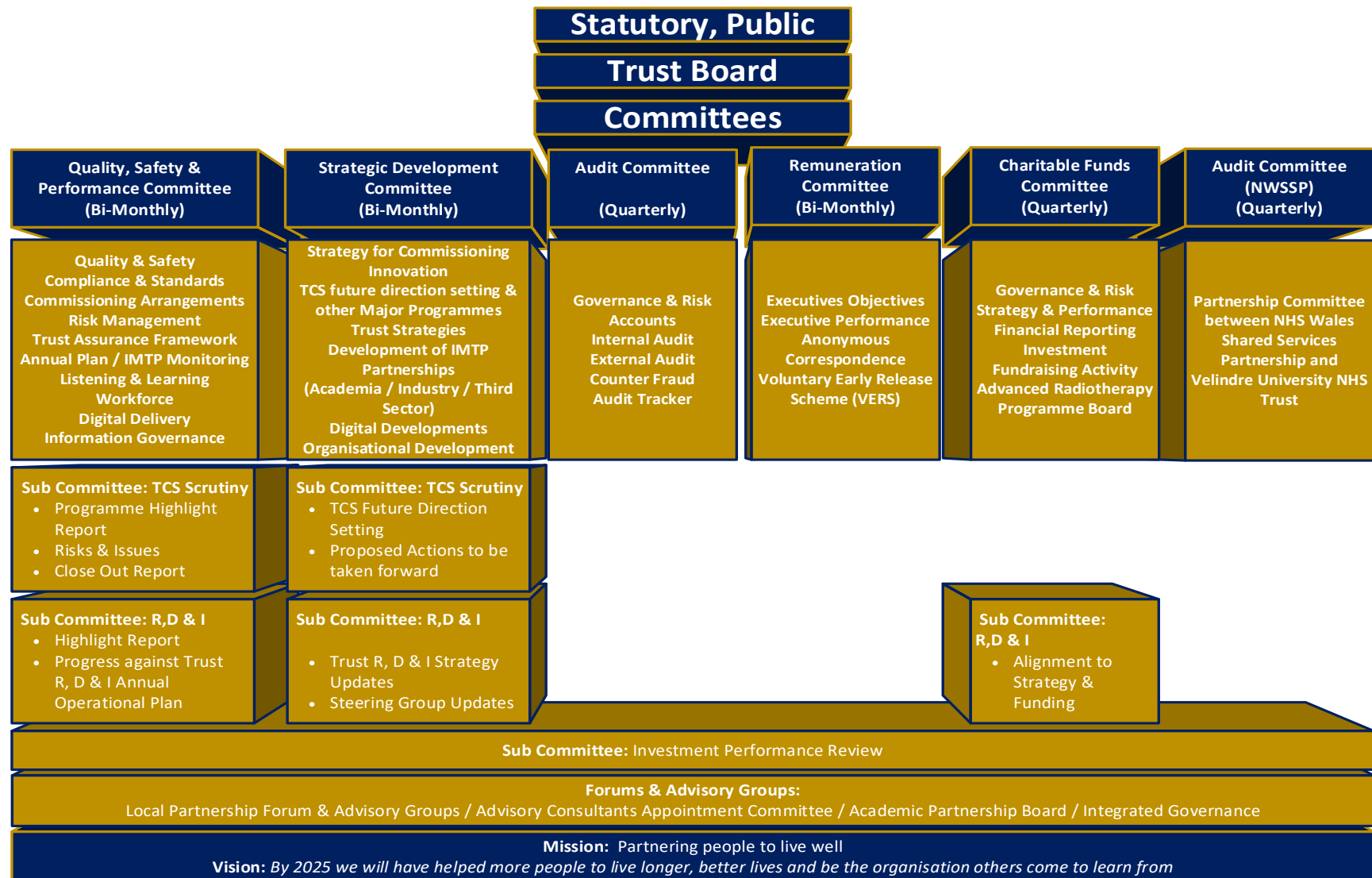
8. REVIEW

8.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

9. CHAIR'S ACTION ON URGENT MATTERS

- 9.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 9.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



Strategic Development Committee

Terms of Reference & Operating Arrangements

Developed:	November 2020
Approved:	
Next Review Due:	October 2021

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".
- 1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Strategic Development Committee**. The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

- 2.1 The purpose of the Strategic Development Committee "the Committee" is to provide:
- Evidence based and timely **advice** to the Board to assist it in discharging its functions and responsibilities with regard to the:
 - strategic direction
 - strategic planning and related matters
 - organisational development
 - digital services, estates and other enabler services
 - sustainable development and the implementation of strategy through the spirit and intention of the Well Being of Future Generations Act
 - investment in accordance with Value-based healthcare
 - **Assurance** to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.
- 2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 With regard to its role in providing advice to the Board on strategic direction and organisational development, the Committee will:
- Oversee the development of the Trust's strategies and plans which set out how plans the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.
 - Regularly review whether the Trust is developing a strategic approach, which

provides it with the greatest opportunity to fulfil its duties under the Well-being of Future Generations (Wales) Act 2015 by means of the application of the Act's Sustainable Development Principle.

- Review the arrangements and contents of key plans to ensure alignment with the Trusts strategic goals and objectives, including the Trust's Integrated Medium Term Plan (IMTP) in accordance with above.
- Review the Trust's Capital Plan to ensure alignment with key Trust strategies, plans (IMTP) and sustainable development principles.
- Review Trust developments involving significant investment or modernisation.
- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

3.2 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.

Authority

3.3 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and
- Any other Committee, sub Committee, or group set up by the Board to assist it in the delivery of its functions.
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.
- The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.
- To approve policies relevant to the business of the Committee as delegated by the Board.

Access

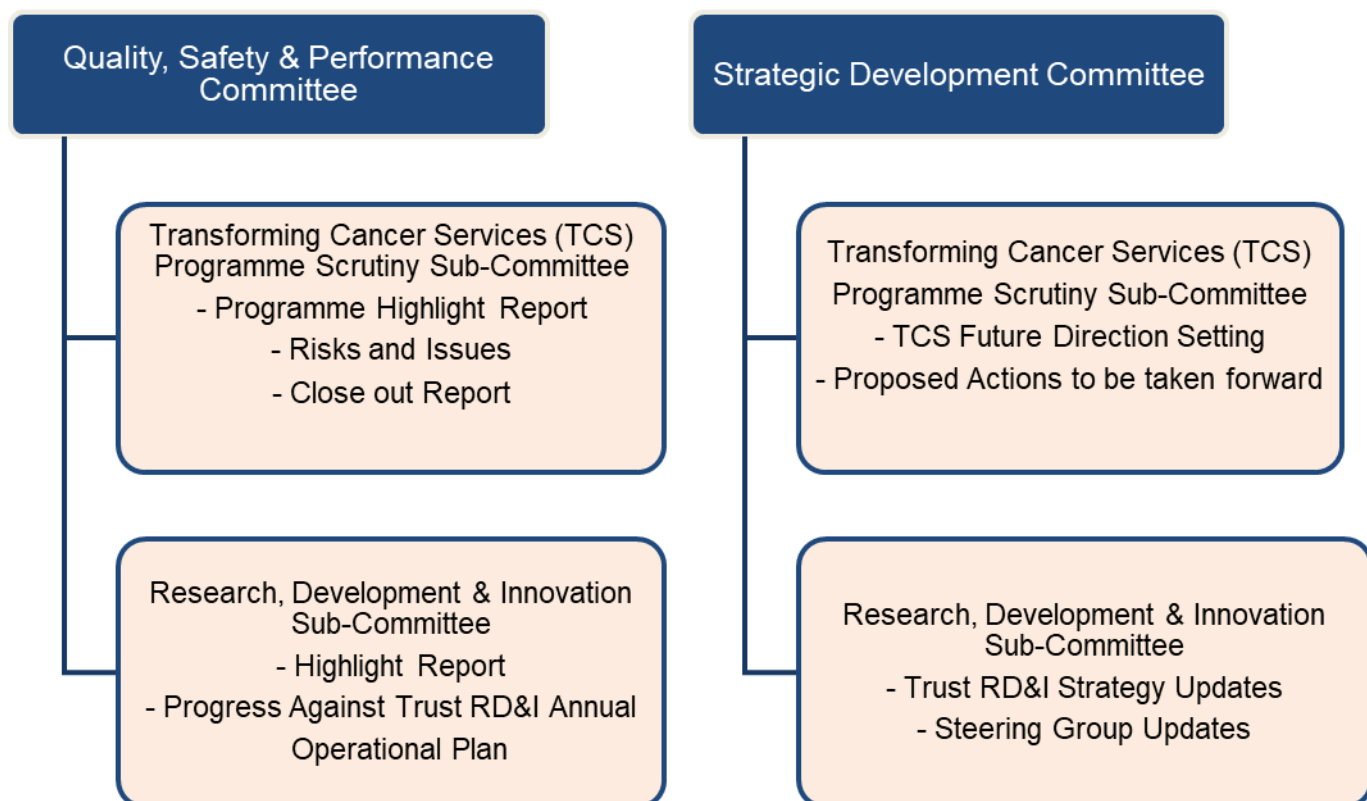
3.4 The Chair of the Strategic Development Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

4.1 Members

A minimum of two (2) members comprising:

Chair Independent member of the Board (Non-Executive Director)

One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2 Attendees:

- Chief Executive Officer
- Director of Strategic, Transformation, Estates, Planning & Digital
- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director
- Chief Operating Officer
- Divisional Directors
- Director of Corporate Governance
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Assistant Director of Planning
- Associate Director of Organisational Development and Workforce
- Associate Director of Digital
- Assistant Director of Communications & Engagement
- Director of Commercial and Strategic Partnerships

The Committee welcomes attendance at Committee meetings by staff from within the organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.3 Secretariat

As determined by the Director of Corporate Governance.

4.4 Member Appointments

The membership of the Committee shall be determined by the Board based on the recommendation of the Trust Chair – taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

4.5 Support to Committee Members

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

5.1 Quorum

At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.

5.2 Frequency of Meetings

Meetings shall be held bi-monthly, consistent with the Trust's annual plan of Board Business.

5.3 Withdrawal of individuals in attendance

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business: and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.4 The Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports.
- Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.

7.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

- 10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Next Review Due:	October 2021

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that *"The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.
- 1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.
- 1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

- 2.1 The purpose of the Audit Committee ("the Committee") is to:
- **Advise** and **assure** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.
- 2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:
- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:
 - the organisation's ability to achieve its objectives,
 - compliance with relevant regulatory requirements, standards, quality

and service delivery requirements and other directions and requirements set by the Welsh Government and others,

- the reliability, integrity, safety and security of the information collected and used by the organisation,
- the efficiency, effectiveness and economic use of resources, and
- the extent to which the organisation safeguards and protects all its assets, including its people

to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;
- The Schedule of Losses and Compensation;
- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);
- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;
- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.
- 3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
- 3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:
 - The **comprehensiveness** of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non clinical; and
 - The **reliability and integrity** of these assurances.
- 3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:
 - There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
 - There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
 - There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
 - There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;
 - The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
 - The work carried out by the whole range of external review bodies is brought

to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that
- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

- 3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:
- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
 - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.
- 3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.
- 3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

- 3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.
- 3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.
- 3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors

and other relevant senior staff.

Sub Committees

- 3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

- 4.1 A minimum of three (3) members, comprising:

Chair Independent member of the Board (~~Non-Executive Director~~)

~~Vice Chair~~ ~~Independent member of the Board~~

~~Members~~ ~~Two~~ ~~One~~ independent members of the Board (~~Non-Executive Directors~~)

[one member should be a member of the Quality, ~~&~~ Safety & Performance Committee]

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

- 4.2 In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.*)

Executive Director of Finance ~~& Informatics~~

Director of Corporate Governance

~~Chief Operating Officer~~

Head of Internal Audit

Local Counter Fraud Specialist

Representative of the Auditor General for Wales

By invitation

The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

- 4.1 Secretary As determined by the Director of Corporate Governance

Member Appointments

- 4.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.
- 4.3 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

- 4.4 The Director of Corporate Governance, on behalf of the Committee Chair, shall:
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
 - Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Workforce & Organisational Development.

5. COMMITTEE MEETINGS

Quorum

- 5.1 At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

- 5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Withdrawal of individuals in attendance

- 5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

- 6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

- 6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:
- Joint planning and co-ordination of Board and Committee business; and
 - Sharing of information
- in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.
- 6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.
- 6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 The Committee Chair shall:
- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;
 - Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
 - Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.
- 7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.
- 7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum [*as per section on Committee meetings*]
- Notice of meetings
- Notifying the public of Meetings
- Admission of the public, the press and other observers

Cross reference with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Next Review Due:	October 2021

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that *"The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees"*.
- 1.2 In accordance with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. CONSTITUTION

- 2.1 The Velindre University NHS Trust Board was appointed as corporate trustee of the charitable funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and that its Board serves as its agent in the administration of the charitable funds held by the Trust.
- 2.2 The purpose of the Committee" is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

3. SCOPE AND DUTIES

- 3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the charitable funds in accordance with their respective governing documents.
- 3.2 To ensure that the Trust policies and procedures for charitable funds investments are followed. To make decisions involving the sound investment of charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:-
 - Trustee Act 2000
 - The terms outlined in the Velindre NHS Trust Charity's Governing Documents
- 3.3 At least twice a year, receive highlight reports from the Executive Director of Finance & Informatics in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.
- 3.4 To oversee and monitor the functions performed by the Executive Director of Finance & Informatics as defined in Standing Financial Instructions.
- 3.5 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

- 3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.
- 3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

4. DELEGATED POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR OF FINANCE & INFORMATICS

- 4.1 The Executive Director of Finance & Informatics has prime responsibility for the Trust's Charitable Funds as defined in the Trust's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Executive Director of Finance & Informatics are:-

- Administration of all existing charitable funds.
- To identify any new charity that may be created (of which the Trust would also be Trustee). Ensuring that all legal requirements are followed in the creation of any new charity in order to formalise the governing arrangements.
- Provide guidelines with response to donations, legacies and bequests, fundraising and trading income.
- Responsibility for the management of investment of funds held on trust.
- Ensure appropriate banking services are available to the Trust.
- Prepare reports to the Trust Board including the Annual Accounts and Annual Report.

5. AUTHORITY

- 5.1 The Committee is empowered with the responsibility for:-

- Overseeing the day to day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the Trustee and the requirements of the Trust's Standing Financial Instructions
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power the Committee must ensure that:
 - a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
 - b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
 - c) The performance of the person or persons exercising the delegated power is regularly reviewed.

d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2012.

e) Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance & Informatics.

- Ensuring that the banking arrangements for the charitable funds are kept entirely distinct from the Trust's NHS funds.
- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.
- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.
- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.
- Obtaining appropriate professional advice to support its investment activities.
- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;
- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

5.3 Approve policies relevant to the business of the Committee as delegated by the Board.

5.4 Sub Committees

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the *'Charitable Funds Investment Performance Review Sub*

Committee, to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

In addition, the Trust Research, Development & Innovation Sub-Committee has been established to act as the 'front door' for all RD&I business at Board level. The RD&I Sub Committee will feed into the Charitable Funds Committee for alignment with strategy and funding.

6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
Members	Independent Member of the Board (Non-Executive Director) The Trust's Chief Executive and Executive Director of Finance & Informatics (one of which at any one meeting may be represented by a Nominated Representative in their absence)

Attendees

6.2 In attendance The Committee may require the attendance for advice, support and information routinely at meetings from:

- Charity Director
- Chief Operating Officer
- Director Velindre Cancer Centre (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Charitable Funds Accountant
- Deputy Director of Finance
- Head of Fundraising
- Head of Corporate Governance (*Charity Governance Lead*)
- Head of Communications

By invitation,

The Committee Chair may invite:

- any other Trust officials; and/or
- any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

- 6.3 Secretary As determined by the Director of Corporate Governance

Member Appointments

- 6.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.
- 6.5 Applicable to Independent Members only. Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.
- 6.6 In order to demonstrate that there is a visible independence in the consideration of decisions and management of charitable funds from the Trust's core functions, the Board should consider extending invitations to the Charitable Funds Committee to individuals outside of the Board. One option might be to seek representation from the Patient Liaison Group.

Support to Committee Members

- 6.7 The Director of Corporate Governance, on behalf of the Committee Chair, shall:
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
 - Ensure and co-ordinate the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Organisational Development & Workforce.

7. COMMITTEE MEETINGS

Quorum

- 7.1 At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member ~~(Non-Executive Director – one of whom is the Chair or Vice Chair)~~ and one must be the Executive Director of Finance & Informatics or Nominated Representative.

Frequency of meetings

- 7.2 Meetings shall be held every three months and otherwise as the Committee Chairs deems necessary - consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

- 7.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 8.1 The Committee will only consider Research and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation **Sub-Committee**. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.
- 8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 8.3 The Committee, through its Chair and members, shall work closely with the Board and, *[where appropriate, its Committees and Groups]*, through the:
- joint planning and co-ordination of Board and Committee business; and
 - appropriate sharing of information
- in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.
- 8.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9. REPORTING AND ASSURANCE ARRANGEMENTS

- 9.1 The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in their capacity as Trustees. This may include, where appropriate, a separate meeting with the Board.
- 9.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year.
- 9.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 10.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum

Cross reference with the Trust Standing Orders.

11. REVIEW

- 11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

12. CHAIR'S ACTION ON URGENT MATTERS

- 12.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Independent Members of the Committee. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 12.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Remuneration & Terms of Service Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Next Review Due:	October 2021

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".
- 1.2 In line with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Remuneration & Terms of Service Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

- 2.1 The purpose of the Remuneration & Terms of Service Committee "the Committee" is to provide:
- **advice** to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Assembly Government; and
 - **assurance** to the Board in relation to the Trust's arrangements for the remuneration and terms of Service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.

and to perform certain, specific functions on behalf of the Board.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 The Board had delegated the following specific powers to the Committee;
- To consider and ratify Voluntary Early Release scheme applications and severance payments
- in line with Standing Orders and extant Welsh Assembly Government guidance.
- 3.2 With regard to its role in providing advice and assurance to the Board, the Committee will comment specifically upon the:
- remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service

as determined from time to time by the Assembly Government are applied consistently;

- objectives for Executive Directors and other VSMS and their performance assessment;
- performance management system in place for those in the positions mentioned above and its application;
- proposals to make additional payments to consultants to include any additional sessions or allowances payable to Senior Medical Staff for managerial duties; and
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Assembly Government guidance.

Authority

- 3.3 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust, relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:
- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
 - any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.
- 3.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.
- 3.5 Approve policies relevant to the business of the Committee as delegated by the Board

Sub Committees

- 3.6 The Committee may, subject to the approval of the Trust Board, establish Sub Committees or task and finish Groups to carry out on its behalf specific aspects of Committee business. The following Sub Committees/task and finish Groups have been established:
- None currently.

4. MEMBERSHIP

Members

4.1 A minimum of two (2) members, comprising:

Chair or	Vice Chair of the Board (Non-Executive Director)
Members	At least one other independent member of the Board (Non-Executive Director)

The Chair of the Audit Committee (or equivalent) will be appointed to this Committee ~~either as Vice-Chair or a~~ member

The Trust Chair may decide the business of the Remuneration Committee requires the attendance of all Independent Members and as such extend an invite to all Independent Members

In attendance

4.2 By invitation The Committee Chair may invite:

- the Chief Executive
- the Executive Director of Human Resources;/Workforce & Organisational Development
- any other Trust officials; including a Trade Union Representative from the Trust Board and/or
- any others from within or outside the organisation
- to attend all or part of a meeting to assist it with its discussions on any particular matter (except when issues relating to their personal remuneration and terms and conditions are being discussed).

Secretariat

4.3 Secretary as determined by the ~~Director of Corporate Governance Board Secretary~~

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements or directions made by the Assembly Government.

4.5 Members shall be appointed to hold office for any period during their appointment as Board Member of the Trust. Continued membership is subject to being a full Member of the Board.

Support to Committee Members

- 4.6 The ~~Director of Corporate Governance Board Secretary~~, on behalf of the Committee Chair, shall:
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
 - ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Human Resources/Workforce & Organisational Development

5. COMMITTEE MEETINGS

Quorum

- 5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair of the Board.

Frequency of Meetings

- 5.2 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

- 5.3 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability in relation to its role as Corporate Trustee.
- 6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of appropriate information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework. *This will be achieved primarily through the Independent Members Group who will include 'Integrated Governance' on their agenda at least twice a year.*

- 6.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 The Committee Chair shall:
- report formally and on a timely basis to the Board on the Committee's activities, in a manner agreed by the Board;
 - bring to the Board's specific attention any significant matter under consideration by the Committee;
 - ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.
- 7.2 The ~~Director of Corporate Governance Board Secretary~~, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.
- 7.3 The Committee shall provide a written, annual report to the board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum [*cross reference with the Standing Orders*]

9. REVIEW

- 9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Transforming Cancer Services Programme

Scrutiny **Sub-Committee**

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Next Review Due:	October 2021

1. INTRODUCTION

- 1.1 Within 3.1.1 of the Trust's standing orders it provides that *"The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.

- 1.2 ~~In line with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the Transforming Cancer Services (TCS) Programme Scrutiny Committee.~~

The Quality, Safety & Performance Committee and Strategic Development Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare and the strategic and organisational development of the Trust.

- 1.3 ~~As part of their functions, the Quality Safety and Performance Committee and the Strategic Development Committee are supported by The Trust Board has approved the creation of the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee to scrutinise the programme governance arrangements for the TCS Programme, which extends to its constituent projects. At a project level the Sub-Committee will examine, Project arrangements, the application and project management methodologies, monitor project performance, risk management, progress and provide assurance to the Quality, Safety and Performance Committee. Assurance on development or proposed changes to the programme scope will be provided to the Strategic Development Committee. Board.~~
- 1.4 The detailed terms of reference and operating arrangements set by the ~~Quality, Safety and Performance Committee and Strategic Development Committee Board~~ in respect of this Sub-Committee are set out below.

2. PURPOSE

- 2.1 The purpose of the Transforming Cancer Services (TCS) Programme Scrutiny ~~Sub~~-Committee is to:
- Provide assurance that the leadership, management and governance arrangements are sufficiently robust to deliver the outcomes and benefits of the programme.
 - Scrutinise the progress of the programme and provide the Trust Board with assurance that implementation is effective, efficient and within the budget available.

- Undertake any other scrutiny activity relating to the TCS Programme as directed by the Trust Board or Senior Responsible Owner (SRO).
 - Seek advice and guidance from appropriate Technical Advisors as well as the MIM Transactor (if relating to the nVCC Project) to assist the Committee with their scrutiny of the TCS Programme.
 - Provide assurance to the Trust Board on all aspects of the TCS Programme in relation to approvals sought on all decisions reserved for the full Board.
 - Receive all audit, gateway and assurance reviews pertaining to the programme or its constituent projects and provide assurance (or otherwise) to the Trust that the programme is being delivered in accordance with all professional, financial and Trust standards.
 - Provide assurance to the **Trust** Board and support to the Senior Responsible Officer in signalling the TCS closure activities once it has met its objectives.
- 2.2 Where appropriate, the Committee will advise the Trust Board and the Accountable Officer on where, and how, its system of assurance in relation to the TCS Programme may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Trust Board, the **Sub**-Committee will fulfil the following functions:

3.1 Strategy and Policy Development

- Scrutinise programme and project documentation to ensure the direction of the TCS Programme remains within the scope and parameters set by the Trust Board and its alignment with the external commissioner and political environment.
- Scrutinise and provide assurance that the Programme and its constituent projects are conducted in line with the Trust's requirements on policy and legislative compliance, best practice and within the Trust's governance framework.

3.2 Governance, Monitoring and Review

The **Sub**-Committee will, in respect of its assurance role:-

- Provide assurance that the Programme has a clear and consistent strategic direction of travel aligned with the Trust Boards requirements; strong and effective leadership; clear and transparent lines of accountability and responsibility; and effective reporting to key stakeholders and decision-makers.

- Provide assurance that Programme and Project governance arrangements are appropriately designed, proportionately applied and implemented and are operating appropriately to ensure the provision of a high quality programme and project management delivery.
- Undertake scrutiny and assurance of the Programme progress against the master programme plan, seeking explanations and remedies for any deviation from Programme timelines. It will report any concerns to the Trust Board as and when appropriate and necessary.
- Undertake scrutiny and assurance of Programme risks, issues and mitigating actions to satisfy itself that they can be placed back under the required levels of control.
- Scrutinise all sources of independent assurance in relation to the delivery of the Programme (e.g. Internal/External Audit, Independent Reviews, Gateway Reviews, CAP etc.) and scrutinise and monitor the organisation's response to independent reviews.
- Provide assurance that there are robust monitoring and management arrangements in place to identify important enablers and dependencies between the programmes projects, as failure to do so could impact on the programmes critical path.
- Scrutinise and assure that the Programme and Project expenditure against the budget allocated is appropriate and managed effectively.

3.4 Authority

- The Sub-Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Sub-Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Sub-Committees remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:
 - Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and
 - Other Committee, sub Committee, or group set up by the Board (including the Project Board) to assist it in the delivery of its functions.
 - Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and
 - By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- Provide assurance that any proposals /actual amendments to delegated limits as necessary in relation to the all TCS Projects are in accordance with the Trust Boards direction and it's Standing Orders and Statutory Financial Instructions.
- The **Sub**-Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.5 Access

The Chair of the TCS Programme Scrutiny **Sub**-Committee shall have reasonable access to Executive Directors, Directors and other relevant staff.

4. MEMBERSHIP

4.1 Members

A minimum of three (3) members to include:

Chair Independent member of the Board (Non-Executive Director)

Vice Chair ~~Independent member of the Board (Non-Executive Director)~~

~~One~~ Two (~~1-2~~) other Independent members of the Board (Non-Executive Director)

Other Trust Board members are extended an open invitation to attend all/any meeting

4.2 Attendees

Core Attendance;

- Chief Executive Officer/ Senior Responsible Owner (~~Chair~~)
- TCS Programme Director
- Executive Medical Director
- Executive Director of Nursing, Therapies and Clinical Scientists
- Director of Corporate Governance
- Executive Director of Organisational Development and Workforce
- Executive Director of Finance
- Director of Commercial and Strategic Partnerships
- Director Velindre Cancer Centre
- Chief Operating Officer

4.3 As Requested: Project Executives and other Programme / Project Staff

- Project Executive Project 1
- Project Executive Project 2

- Project Executive Project 3
- Project Executive: Project 4
- Project Executive: Project 5
- Project Executive: Project 6

The Committee Chair may extend invitations to others from within or outside the organisation who the Committee consider should attend, taking account of the matters under consideration of each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

The membership of the Committee shall be determined by the Board based on the recommendation of the Trust Chair – taking account of the balance of skills and expertise necessary to deliver the Committee’s remit and subject to any specific requirements or directions made by the Welsh Government

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

4.6 **Support to Committee Members**

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust’s overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

5.1 **Quorum**

At least two (2) members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or ~~Vice-Chair~~. - If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.

5.2 **Frequency of Meetings**

Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust’s annual plan of Board Business.

5.3 Withdrawal of individuals in attendance

The Committee Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business:
and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the **Quality, Safety and Performance Committee, the Strategic Development Committee Board** and the Accountable Officer on the **Sub-Committee's** activities. This includes verbal updates on activity and the submission of written highlight reports by **exception** throughout the year and an **annual Committee report**.
- Bring to the Board's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees/Groups of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 ~~The Committee shall produce a written annual report to the Board on its work. The report will also include the results of the Committees self-assessment and evaluation.~~

- 7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum – as per section 5.1 above.
- Cross reference with the Trust Standing Orders.

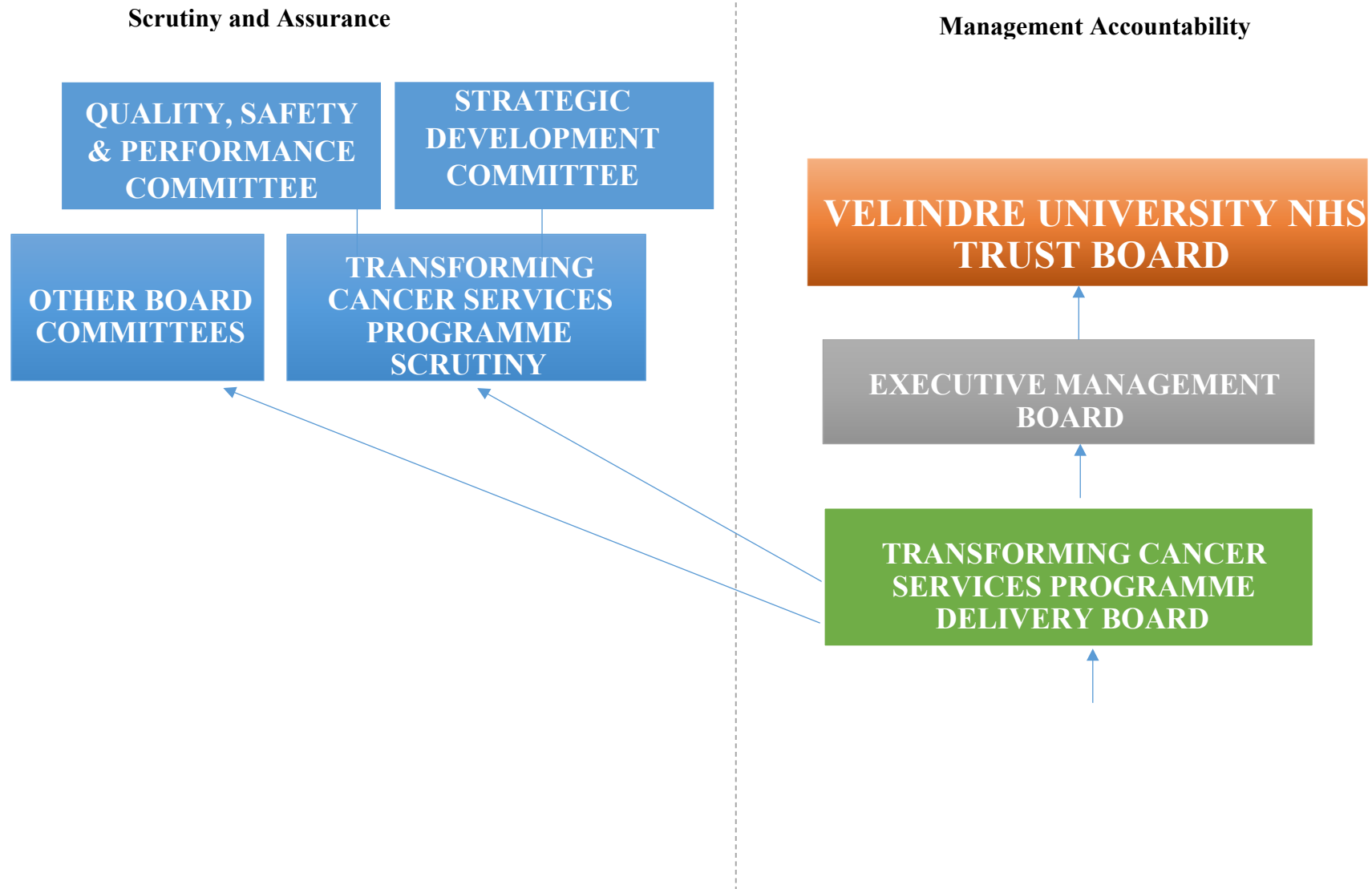
8. REVIEW

- 8.1 These Terms of Reference shall be reviewed annually by the Sub-Committee with reference to the Trust Board.

9. CHAIR'S ACTION ON URGENT MATTERS

- 9.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 9.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Structure and governance arrangements



Research, Development & Innovation **Sub**-Committee (RD&I)

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Next Review Due:	October 2021

1. INTRODUCTION

- 1.1 Within 3.1.1 of the Trust's standing orders it provides that *"The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.
- 1.2 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.
- 1.3 As part of the aforementioned Committee functions, the Research, Development & Innovation (RD&I) Sub-Committee has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:
- monitor the performance and delivery of RD&I on behalf of the Quality, Safety & Performance Committee;
 - develop the RD&I Strategy on behalf of the Strategic Development Committee; and
 - review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.
- ~~1.4 In-line with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the Research, Development & Innovation Committee (RD&I). The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below:~~
- 1.5 Innovation and Research are defined as follows:
- **Innovation** - is the exploration of emerging technologies and / or processes that positively impact healthcare by improving the care experience, individual and population health, and reducing costs.
 - **Research** - is designed and conducted to generate new knowledge.

2. PURPOSE

2.1 The purpose of the RD&I ~~Sub~~-Committee is to provide:

- Strategy and policy oversight for ~~Research, Development & Innovation and Research~~ activities at the Trust and for any Strategy that requires Board approval this to then be taken to the Trust Strategic Development Committee. ~~advise on and monitor performance in these areas.~~
- Receive assurance on the monitoring of performance – [through Quality lens]
- [Exception reporting] and as defined by the Quality, Safety and Performance Committee, elements of this performance monitoring assurance may need to also be taken there – according to performance, quality, assurance frameworks and exception reporting criteria for that Committee.
- Promotion and encouragement of a ~~n~~ ~~Research & Innovation and Research~~ ethos and culture which is integral to the Trusts vision, mission and values.
- ~~Evidence based timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regards to the quality and safety of Innovation and Research activity. In the relation to research this includes activity carried out within the Trust both as a research sponsor and host organisation.~~
- Assurance to the Board in relation to the Trust's arrangements for ensuring compliance with ~~the , and the EU Clinical Trials Directive 2004 as amended from time to time~~ the UK Policy Frameworks for Health & Social Care Research as amended from time to time.
- ~~Foster collaboration and make recommendations on adoption and dissemination.~~
- Consideration of relevant matters with reference to the parameters identified for risk appetite in relation to research, development and innovation as set by the Board.
~~Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.~~

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Board, the Committee will fulfil the following functions:

3.1 Strategy & Policy Development

- Promote and encourage a **Research & Innovation and Research** ethos and culture within the Trust.
- Oversee the development of all **Research & Innovation and Research** strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of Innovation and Research activity.
- ~~Consider the governance implications arising from the development of Trust Innovation and Research related corporate strategies and plans as well as those of its stakeholder Organisations.~~
- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.
- **Matters of Strategic development for the assurance and approval of the Trust Board to be escalated to the Trust Strategic Development Committee and, as appropriate, on to Trust Board.**

3.2 Strategy & Policy Approval

- Approve policies relevant to the business of the Committee as delegated by the Board.
- Scrutinise Research and/or Innovation ~~Proposals and/or~~ Business cases which exceed the delegated limits of the Chief Executive to consider prior to formal Trust Board approval.

3.3 Monitoring and Review

- The **Sub-Committee** will, in respect of its assurance role, seek assurance that research governance and innovation arrangements are appropriately designed, implemented and are operating appropriately to ensure the provision of a high quality Innovation and Research service.

- To achieve this, the ~~Sub-Committee will need assurance that the following aspects of ensure in relation to all aspects of Innovation and~~ Research & Innovation development ~~are being effectively managed. that:~~
- The safety, rights, dignity and wellbeing of participants in Innovation and Research development projects is above all other considerations.
- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability
- The diversity of the organisation's patients, service users, donors and staff is valued and that their active participation in the development, undertaking and use of Innovation and Research is promoted.
- There is close collaboration with partner Organisations in higher education to improve quality, promote joint working and avoid unnecessary duplication of functions. ~~In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board.~~
- The organisation ensures compliance with appropriate legislation and regulation such as the, UK Policy Framework for Health and Social Care Research 2017 the EU Clinical Trials Directive 2004 as amended, Good Laboratory Practice, Good Manufacturing Practice in manufacturing products for clinical trials and Good Clinical Practice in the conduct of all clinical Innovation and Research activities as appropriate.
- Systems are in place to monitor compliance with standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Innovation and Research activity.
- ~~The Committee will monitor the cost of supporting Innovation and~~ Research, and ~~Innovation will seek assurance that all~~ expenditure is accounted for and complies with audit requirements and requirements of external funders or sponsors as appropriate.
- The Committee will scrutinise research and/or innovation proposals and/or business cases that are seeking charitable funding PRIOR to submission to the Charitable Funds Committee, in order to provide assurance on the quality and safety of RD&I related activity.
- When research or innovation findings have commercial potential the Trust takes action to protect and exploit them in collaboration with its Innovation and Research partners and where appropriate commercial Organisations.

- ~~Scrutinise performance against key metrics.~~

3.4 ~~Authority~~

- ~~The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:~~
- ~~Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and~~
- ~~Other Committee, sub Committee, or group set up by the Board to assist it in the delivery of its functions.~~
- ~~By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.~~
- ~~The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.~~
- ~~To approve policies relevant to the business of the Committee as delegated by the Board.~~

3.5 Access

The Chair of the Research, Development & Innovation **Sub-Committee** shall have reasonable access to Executive Directors and other relevant senior staff.

3.6 ~~Sub Committees~~

~~None currently identified.~~

~~The Committee may, subject to the approval of the Trust Board, establish sub Committees to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees have been established.~~

4. MEMBERSHIP

4.1 Members

A minimum of two (2) members to include:

Chair Independent member of the Board (Non-Executive Director)
or delegated Independent Board member

~~One Independent Member of the Board (Non-Executive Director)~~

~~Vice Chair Independent member of the Board (Non-Executive Director)~~

4.2 Attendees

In attendance

- Executive Director with responsibility for ~~RD&I&D~~ currently Medical Director
- Executive Director of Finance & ~~Informatics~~ or nominated officer with ~~RD&I&D~~ funding responsibilities
- ~~Medical Director – Welsh Blood Service~~
- ~~Associate Medical Director with responsibility for R&D~~
- Clinical Director (or Nominated Deputy) – Velindre Cancer Centre
- ~~Executive Director of Nursing AHP and Health Sciences Service Improvement~~
- Director of Corporate Governance
- Head of RD&I Strategy
- Representative - Velindre Cancer Centre Strategic Management Team
- Representative – Welsh Blood Service Strategic Management Team
- ~~WBS RD&I Lead~~
- ~~Divisional Innovation and Research Leads~~
- Trust ~~Head of Research & Development~~
- ~~Trust Research & Development Manager and Sponsorship Representative~~
- Service User/Lay representatives
- Staff Side Representative

4.3 By invitation

The ~~Sub~~-Committee Chair may extend invitations as required to the following:

- Information Governance Manager (in advisory capacity)
- Divisional Directors
- Representatives of ~~stakeholder partnership~~ Organisations

As well as others from within or outside the organisation who the **Sub-Committee** consider should attend, taking account of the matters under consideration of each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

~~The membership of the Committee shall be determined by the Board based on the recommendation of the Trust Chair taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government~~

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

4.6 **Support to Committee Members**

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. SUB-COMMITTEE MEETINGS

5.1 **Quorum**

At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair ~~or Vice-Chair~~. ~~If the Chair is not present an agreement as to who will Chair form the Independent Members in their absence.~~

5.2 **Frequency of Meetings**

Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.

5.3 Withdrawal of individuals in attendance

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 6.1 Although the Board has delegated authority to the **Sub-Committee** for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.
- 6.2 The **Sub-Committee** is directly accountable to the **Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee Board** for its performance in exercising the functions set out in these terms of
- 6.3 ~~The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:~~
- ~~• Joint planning and co-ordination of Board and Committee business; and~~
 - ~~• Sharing of information~~
- ~~In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.~~
- ~~6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.~~
- 6.4 The **Sub-Committee** shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 The Committee Chair shall:
- ~~• Report formally, regularly and on a timely basis to the:~~
 - ~~i. Quality, Safety & Performance Committee on the performance and delivery of RD&I;~~

- ii. Strategic Development Committee Board on strategic development and updates to the RD&I Strategy; and
- iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives. This includes verbal updates on activity and the submission of written Highlight Reports.
- ~~Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and~~
- ~~Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.~~

7.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Sub-Committee.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Sub-Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

~~Information Governance & IM&T Committee~~

~~Terms of Reference & Operating Arrangements~~

Reviewed:	February 2019
Next Review Due:	February 2020

1. INTRODUCTION

1.1 The Trust's standing orders provide that *"The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.

1.2 In line with standing orders and the Trust's scheme of delegation, the Board nominate annually a Committee to be known as the **Information Governance & IM&T Committee**. The detailed terms of reference and operating arrangements agreed by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Information Governance & IM&T Committee "the Committee" is to provide:

- evidence based and timely **advice** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the:
 - technological advancements and structures
 - sustainability and creativity
 - Expertise and development
 - quality and integrity;
 - safety and security; and
 - appropriate access and use of information and information technology to support its provision of high quality healthcare; and
- **assurance** to the Board in relation to the Trust's arrangements for developing, creating, collecting, storing, safeguarding, disseminating, sharing, using and disposing of information and information technology in accordance with its:
 - stated objectives;
 - legislative responsibilities, e.g., the Data Protection Act and Freedom of Information Act; and
 - any relevant requirements and standards determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of advice to the Board:

- ~~oversee the initial development of the Trust's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;~~
- ~~consider the information governance implications arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners~~
- ~~consider the Information Governance and IM&T implications for the Trust's of review reports and actions arising from the work of external reviewers.~~

~~3.2 The Committee will, in respect of its assurance role, seek assurances that information governance and IM&T arrangements are appropriately designed and operating effectively to ensure the development, sustainability, creativity, safety, security, integrity and effective use of information and information systems to support the delivery of high quality, safe healthcare across the whole of the Trust's activities.~~

~~3.3 To achieve this, the Committee's programme of work will be designed to ensure that, in relation to all aspects of Information Governance and Information Management and Technology:~~

- ~~there is clear, consistent strategic direction, strong leadership and transparent lines of accountability; acknowledging that Local and All Wales responsibilities are clearly defined and considered to ensure organisational decision taking supports information strategies for NHS Wales.~~
- ~~ensuring that Information Governance and Information Management and Technology Policies, Procedures and Strategies consistent with internal and external requirements are approved and implemented as appropriate.~~
- ~~ensure prioritisation off Capital IT spending for inclusion in the Trust Capital Programme is achieved.~~
- ~~the organisation, at all levels (division/ clinical team) has a citizen-centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information systems;~~
- ~~the handling and use of information and information systems across the organisation (division/clinical team) is consistent, and based upon agreed standards;~~
- ~~the workforce is appropriately selected, trained, supported and responsive to requirements in relation to the effective handling and use of information and information systems — consistent with the interests of patients and the public;~~

- ~~there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);~~
- ~~risks are actively identified and robustly managed at all levels of the organisation;~~
- ~~the integrity of data and information is protected, ensuring valid, accurate, complete and timely data and information is available to support decision making across the organisation;~~
- ~~and that systems used to maintain the above reflect the current responsibilities of the Trust at both a local and national level;~~
- ~~there is coherent and consistent IT strategy that will lead and innovate in the uses of information systems and the information held on them;~~
- ~~the board is further assured that key decisions on the development of Information Governance and IM&T Strategies are consistent with those that preside over the legislative requirements of both the Data Protection Act and Freedom of Information Act.~~
- ~~there is continuous improvement in the handling, management and use of information systems and data across the whole organisation — evidenced through the Health and Care Standards — Health in Wales.~~
- ~~promote and develop a culture of information openness that supports current legislation.~~
- ~~the Trust is meeting its legislative responsibilities, e.g., Data Protection and Freedom of Information Acts, as well as complying with national Information Governance policies and guidance;~~
- ~~the strategy encapsulates the requirements for robust Information Governance and Information Management & Technology audit arrangements to ensure the identification of Key Actions.~~
- ~~the strategy is developed to ensure that the new systems meet local clinical and business drivers and that the new technologies are aligned with service improvement, workforce development and system reform initiatives. The demands of stakeholder engagement and communication, benefits realisation and dependency management are robust enough to cope with future demands of the service.~~
- ~~to ensure there is clarity about the contribution of IM&T to Trust goals over different timeframes so that the benefits of IM&T investment can be assessed.~~

- ~~To ensure the IM&T governance arrangements that oversee the use of resources and the achievement of the strategic IM&T development plan are accurate and adequate to ensure there is a stronger relationship with the Trust Board and so a greater strategic attention to relationships with stakeholders and neighbouring NHS partners.~~
- ~~all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular that:~~
 - ~~Sources of internal assurance are reliable, and have the capacity and capability to deliver;~~
 - ~~Recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and~~
 - ~~Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through reported incidents, complaints and claims.~~

~~3.4 The Committee will advise the Board on the adoption of a set of key indicators in relation to the quality and effectiveness of information systems against which the Trust's performance will be regularly assessed.~~

~~Authority~~

~~3.5 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:~~

- ~~employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and~~
- ~~any other Committee, Sub Committee or group set up by the Board to assist it in the delivery of its functions.~~

~~3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.~~

~~3.7 Approve policies relevant to the business of the Committee as delegated by the Board.~~

~~Access~~

~~3.8 The Chair of the IG & IM&T Committee shall have reasonable access to Executive Directors and other relevant senior staff.~~

~~Sub Committees~~

~~3.9 The Committee may, subject to the approval of the Trust Board, establish Sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.~~

4. MEMBERSHIP

~~Members~~

~~4.1 A minimum of two (2) members, comprising:~~

~~Chair Independent member of the Board (Non-Executive Director)~~

~~Members At least one other independent member of the Board (Non-Executive Director)~~

~~The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.~~

~~Attendees~~

~~4.2 In attendance~~

~~Chief Executive~~

~~Executive Director of Finance & Informatics~~

~~Associate Director of Informatics~~

~~Data Protection Officer~~

~~Caldicott Guardians~~

~~Divisional Senior Management Team Representatives~~

~~Information Governance Manager~~

~~Head of Business Systems – Welsh Blood Service~~

~~Head of IM&T – Velindre Cancer Centre~~

~~Workforce & Organisational Development Representative~~

~~Head of Corporate Governance~~

~~By invitation The Committee Chair may invite:~~

- ~~- the Chair of the organisation~~
- ~~- any other Trust officials; and/or~~
- ~~- any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.~~

~~Secretariat~~

~~4.3 Secretary As determined by the Director of Corporate Governance~~

~~Member Appointments~~

~~4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.~~

~~4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee with reference to Velindre NHS Trust Chair.~~

~~Support to Committee Members~~

~~4.6 The Director of Corporate Governance, on behalf of the Committee Chair, shall:~~

- ~~▪ Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and~~
- ~~▪ Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce & Organisational Development.~~

~~5. COMMITTEE MEETINGS~~

~~Quorum~~

~~5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair.~~

~~Frequency of Meetings~~

~~5.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Committee deems necessary consistent with the Trust Board Cycle of Business.~~

~~Withdrawal of individuals in attendance~~

~~5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.~~

6. ~~RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS~~

~~6.1 Although the board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the organisation.~~

~~6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.~~

~~6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:~~

- ~~▪ joint planning and co-ordination of Board and Committee business; and~~
- ~~▪ sharing of information~~

~~in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework. This will be achieved primarily through the Independent Members Group who will include 'Integrated Governance' on their agenda at least twice a year.~~

~~6.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.~~

7. ~~REPORTING AND ASSURANCE ARRANGEMENTS~~

~~7.1 The Committee Chair shall:~~

- ~~▪ report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity, the submission of written highlight reports throughout the year and an annual Committee Report.~~
- ~~▪ bring to the Board's specific attention any significant matters under consideration by the Committee;~~
- ~~▪ ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees/Groups of any urgent/critical matters that may affect the operation and/or reputation of the Trust.~~

~~7.2 The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation.~~

~~7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.~~

~~8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS~~

~~8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:~~

- ~~• Quorum – as per section 5.1 above.~~

~~Cross reference with the Trust Standing Orders.~~

~~9. REVIEW~~

~~9.1 These Terms of Reference shall be reviewed annually by the Committee with reference to the Board.~~

~~10. CHAIR'S ACTION ON URGENT MATTERS~~

~~10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.~~

~~10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.~~

~~PLANNING AND PERFORMANCE COMMITTEE~~

~~Terms of Reference & Operating
Arrangements~~

1. INTRODUCTION

- 1.1 ~~The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".~~
- 1.2 ~~In accordance with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Planning and Performance Committee**, "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.~~
- 1.3 ~~These Terms of Reference and Operating Arrangements are based on and compliant with the Board.~~

2. PURPOSE

- 2.1 ~~The purpose of the Committee is to:~~
- ~~▪ To advise and assure the Trust Board on all aspects of planning and performance and the associated arrangements across the Trust.~~
- 2.2 ~~Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how the Trust-wide approach to planning and the Trust's Performance Management Framework may be strengthened and further developed.~~

3. DELEGATED POWERS AND AUTHORITY

- 3.1 ~~With regard to its role in providing advice to the Board on **planning (including financial planning)**, the Committee will:~~
- ~~• Develop and monitor progress against the Trust's Integrated Medium Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board.~~
 - ~~• Advise the Board on aligning service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.~~
 - ~~• Ensure that the Trust maximises its contribution to the realisation of the national well-being goals set out in the Well-being of Future Generations (Wales) Act 2015 in all planning activity.~~

- ~~Review and monitor the Trust's sustainability activities and responsibilities.~~
- ~~Monitor progress against cost improvement programmes.~~
- ~~Ensure that appropriate systems are in place to develop and approve all Business Cases above Chief Executive's authorised limits in line with agreed policy.~~
- ~~Provide initial scrutiny of all business cases above Chief Executive's authorised limits.~~
- ~~Monitor & review the Trust's Capital Programme expenditure.~~
- ~~Ensure a system is in place and running effectively to prioritise schemes from the Trust Capital Programme.~~
- ~~Oversee any Trust developments involving significant investment or modernisation involving finance or staffing issues.~~

3.2 ~~With regard to its role in providing advice to the Board on **performance**, the Committee will:~~

- ~~Monitor and review performance against the Trust's Performance Management Framework.~~
- ~~Monitor outcomes/outputs from service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery.~~
- ~~Ensure areas of significant service/performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation.~~
- ~~Oversee the implementation of Welsh Government Performance Policy across the Trust.~~
- ~~Review the implementation & effectiveness of the Trust's Performance Management Framework.~~
- ~~Receive performance audit reports from Internal and External Audit, agreeing action plans to be incorporated into the Trust Audit Action Plan (monitored by Trust~~

Audit Committee).

~~3.3 To achieve this, the Committee's programme of work will be designed to provide assurance that~~

- ~~• There is an effective planning and performance management cycle that meets the needs of the Board in delivering the Trust's objectives.~~
- ~~• There is effective scrutiny of performance issues and the associated plans to address poor performance.~~
- ~~• There is an effective system in place to consider and respond in a timely manner to performance audits received across the organisation and an effective system in place to monitor progress on actions resulting from performance audits.~~

~~3.4 With regard to its role in providing advice to the Board on **strategic direction** the Committee will:~~

- ~~• Ensure that all strategic developments are informed by the Sustainable Development Principle as defined by the Well-being of Future Generations (Wales) Act 2015.~~

~~Authority~~

~~3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:~~

- ~~• Employee (and all employees are directed to cooperate with any reasonable request made by the Committee).~~
- ~~• Any other Committee, sub-Committee or Group set up by the Board to assist it in the delivery of its functions.~~
- ~~• By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.~~
- ~~• Obtain outside legal or other independent professional advice and to secure the~~

~~attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements.~~

~~3.6 Approve policies relevant to the business of the Committee as delegated by the Board.~~

4. MEMBERSHIP

~~4.1 The core membership of the Committee, as specified in Regulations, is set out below:~~

~~Chair Chairman of the Board (Independent Member)~~

~~Members Independent Member~~

Attendees

~~4.2 The Committee may require the attendance for advice, support and information routinely at meetings from:~~

~~In attendance Chief Executive~~

~~Executive Director of Finance and Informatics~~

~~Executive Director of Nursing and Service Development~~

~~Executive Director of Organisational Development and Workforce~~

~~Director of Strategic Transformation, Planning, Performance and Estates~~

~~Director of Cancer Services~~

~~Director of Welsh Blood Service~~

~~Director of Corporate Governance~~

~~Assistant Director of Planning and Performance~~

~~By invitation The Committee Chair may invite:~~

~~- Any other Trust officials and/or~~

~~- Any others from within or outside the organisation to~~

~~attend all or part of a meeting to assist it with its discussions on any particular matter.~~

Secretariat

~~4.3 As determined by the Director of Corporate Governance.~~

Member Appointments

~~4.4 Appointed Independent Members shall hold office for a period that corresponds with their appointment to the Trust Board.~~

Support to Committee Members

~~4.5 The Director of Corporate Governance, on behalf of the Committee Chair, shall:~~

- ~~▪ Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role.~~
- ~~▪ Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.~~

5. COMMITTEE MEETINGS

Quorum

~~5.1 The Committee may not proceed if any core member (or their appointed deputy) is not present.~~

~~5.2 Prospective members of the Committee should notify the Trust immediately they become aware they are no longer able to attend the Committee on the set date. The Trust should then find an appropriate replacement.~~

Frequency of meetings

~~5.3 Meetings shall be held no less than quarterly and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.~~

6. ~~RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS~~

~~6.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.~~

~~6.2 The Committee, through its Chair and members, shall work closely with the Board and the Strategic Planning and Performance Management Group through the:~~

- ~~▪ joint planning and co-ordination of Board and Committee business; and~~
- ~~▪ appropriate sharing of information~~

~~in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.~~

~~6.3 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.~~

7. ~~REPORTING AND ASSURANCE ARRANGEMENTS~~

~~7.1 A brief report of the Committee should be prepared and signed by the Chair.~~

~~7.2 The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation.~~

8. ~~APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS~~

~~8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:~~

- ~~• Quorum~~
- ~~• Chairs Action on Urgent Matters~~

~~Cross reference with the Trust Standing Orders.~~

9. ~~REVIEW~~

~~9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.~~

~~Quality & Safety Committee~~

~~Terms of Reference & Operating Arrangements~~

Reviewed:	June-2018
Next Review Due:	June-2019

1. INTRODUCTION

1.1 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality and Safety Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality & Safety Committee "the Committee" is to provide:

- evidence based and timely **advice** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and
- **assurance** to the Board in relation to the Trust's arrangements for safeguarding and improving the quality and safety of patient and service user centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** to the Board:

- oversee the initial development of the Trust's strategies and plans for the development and delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;
- consider the implications for quality and safety arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board
- consider the implications for the Trust's quality and safety arrangements from review/investigation reports and actions arising from the work of external regulators.

3.2 The Committee will, in respect of its assurance role, seek assurances that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities.

3.3 To achieve this, the **Committee's programme of work** has been designed to ensure that, in relation to all aspects of quality and safety:

- ~~there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;~~
- ~~the organisation, at all levels (divisional/ team) has a citizen centred approach, putting patients, patient safety and safeguarding above all other considerations;~~
- ~~the care and services planned or provided across the breadth of the organisation's functions (including divisional/ team and those provided by the independent or third sector) is consistently applied, based on sound evidence, clinically effective and meeting agreed standards;~~
- ~~the organisation, at all levels (divisional/ team) has the right systems and processes in place to deliver, from a patients or service user perspective – efficient, effective, timely and safe services;~~
- ~~the workforce is appropriately selected, trained, supported and responsive to the needs of the service, ensuring that professional standards and registration/revalidation requirements are maintained;~~
- ~~there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation;~~
- ~~there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;~~
- ~~risks are actively identified and robustly managed at all levels of the organisation;~~
- ~~decisions are based upon valid, accurate, complete and timely data and information;~~
- ~~there is continuous improvement in the standard of quality and safety across the whole organisation – continuously monitored through the Standards for Health Services in Wales;~~
- ~~all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that:~~
 - ~~sources of internal assurance are reliable~~
 - ~~recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and~~

- ~~lessons are learned from concerns, incidents, complaints and claims.~~

- ~~There is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer.~~

~~3.4—The Committee will advise the Board on the adoption of a set of key indicators of quality of care which will be reflected in the organisations performance framework, against which the Trust's performance will be regularly assessed and reported on through Annual Reports.~~

Authority

~~3.5—The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit and ensuring patient/service user/client and staff confidentiality, as appropriate. It may seek any relevant information from any:~~

- ~~Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and~~
- ~~Any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.~~
- ~~Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.~~
- ~~By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.~~

~~3.6—Approve policies relevant to the business of the Committee as delegated by the Board.~~

Access

~~3.7—The Chair of the Quality & Safety Committee shall have reasonable access to Executive Directors and other relevant senior staff.~~

Sub Committees

~~3.8 The Committee may, subject to the approval of the Trust Board, establish Sub Committees or task and finish Groups to carry out on its behalf specific aspects of Committee business.~~

MEMBERSHIP

Members

~~3.9 A minimum of two (2) members, comprising:~~

~~Chair Independent member of the Board~~

~~(Non Executive Director)~~

~~Vice Chair Independent member of the Board~~

~~(Non Executive Director)~~

~~The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.~~

Attendees

~~3.10 In attendance The Chief Executive~~

~~Executive Directors holding portfolios containing aspects of quality and safety of care – currently Executive Director Nursing & Service Improvement and Medical Director.~~

~~Other Executive Directors should attend from time to time as required by the Committee Chair~~

~~3.11 By invitation The Committee Chair may extend invitations to attend Committee meetings as required to the following:~~

~~Divisional Directors~~

~~Directors of Hosted Organisations~~

~~Corporate Leads holding portfolios containing aspects of quality & safety, currently:~~

~~Quality & Safety Manager~~

~~Claims Manager~~

~~Director of Corporate Governance~~

~~Assistant Director of Nursing & Service Improvement~~

~~Representatives of Partnership organisations~~

~~Public and Patient Involvement Representatives~~

~~Trade Union Representatives~~

~~as well as others from within or outside the organisation who the Committee considers should attend, taking account of the matters under consideration at each meeting.~~

~~Secretariat~~

~~3.12 Secretary As determined by the Executive Director Nursing & Service Improvement~~

~~Member Appointments~~

~~3.13 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair – taking account of the balance of skills and expertise necessary to deliver the Committee’s remit and subject to any specific requirements or directions made by the Welsh Government.~~

~~3.14 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.~~

~~Support to Committee Members~~

~~3.15 The Director of Corporate Governance, on behalf of the Committee Chair, shall:~~

- ~~▪ Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and~~
- ~~▪ Ensure the provision of a programme of organisational development for Committee members as part of the Trust’s overall OD programme developed by the Executive Director of Organisational Development & Workforce~~

4. COMMITTEE MEETINGS

~~Quorum~~

~~4.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.~~

~~Frequency of Meetings~~

~~4.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Committee deems necessary.~~

~~Withdrawal of individuals in attendance~~

- ~~4.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.~~

~~5. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS~~

- ~~5.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.~~

- ~~5.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.~~

- ~~5.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:~~

- ~~■ joint planning and co-ordination of Board and Committee business; and~~
- ~~■ sharing of information~~

~~in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework~~

- ~~5.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.~~

- ~~5.5 The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.~~

~~6. REPORTING AND ASSURANCE ARRANGEMENTS~~

- ~~6.1 The Committee Chair shall:~~

- ~~■ Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee highlight reports and other written reports, as well as the presentation of an annual Quality & Safety report;~~

- ~~Bring to the Board's specific attention any significant matters under consideration by the Committee;~~
- ~~Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Trust.~~

11.2 ~~The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation.~~

11.3 ~~The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.~~

~~7. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS~~

7.1 ~~The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:~~

- ~~Quorum~~
~~Cross-reference with the Trust Standing Orders.~~

~~8. REVIEW~~

8.1 ~~These terms of reference and operating arrangements and Programme of Work shall be reviewed annually by the Committee with reference to the Board.~~

~~9. CHAIR'S ACTION ON URGENT MATTERS~~

9.1 ~~There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.~~

9.2 ~~Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.~~

~~Workforce & Organisational Development Committee~~

~~Terms of Reference & Operating Arrangements~~

Reviewed:	January 2019
Date Approved:	12th February 2019
Approved By:	Workforce and OD Committee
Next Review Due:	January 2020

1. INTRODUCTION

1.1 The Trust's standing orders provide that *"The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees"*.

1.2 In line with the standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the Workforce & Organisational Development Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Workforce and Organisational Development Committee ("the Committee") is:

- To advise and assure the Trust Board on all aspects of Workforce & Organisational Development matters and the associated arrangements across the Trust.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board on **workforce and organisational development**, the Committee will:

- Develop and monitor progress against the appropriate areas and actions of within the Trust's Integrated Medium Term Plan.
- Review appropriate workforce and OD performance information/metrics for the Trust's Performance Management Framework.
- The Committee will, in respect of its assurance role, seek assurances that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, legal and safe workforce practices, processes and procedures.
- Receive and consider Workforce & Organisational Development as strategies appropriate. Providing assurance to the Board that all strategic developments

are informed by the Sustainable Development Principle as defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor and scrutinise internal and external audit reports, and approving management responses to action plans.
- Consider and ratify Welsh Government Workforce & Organisational Development policies, procedures and initiatives prior to implementation across the Trust.
- Advise the Board on aligning service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

3.3 — To achieve this, the Committee's programme of work will be designed to provide assurance that;

- There is an effective planning and performance management cycle that meets the needs of the Board in delivering the Trust's workforce and OD objectives.
- There is effective scrutiny of workforce and OD performance issues and key performance indicators and the associated plans to deliver against these requirements.
- There is an effective system in place to consider and respond in a timely manner to workforce and OD performance audits received across the organisation and an effective system in place to monitor progress on actions resulting from such audits.

Authority

3.4 — The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- ~~• any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.~~
- ~~• obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and~~
- ~~• By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.~~

~~3.5— Approve policies relevant to the business of the Committee as delegated — by the Board.~~

Access

~~3.6— The Chair of the Workforce & Organisational Development Committee shall have reasonable access to Executive Directors and other relevant senior staff.~~

Sub Committees

~~3.7— None currently identified.~~

~~— The Committee may, subject to the approval of the Trust Board, establish Sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.~~

4. MEMBERSHIP

Members

~~4.1— A minimum of two (2) members, comprising:~~

~~— Chair — Independent Member of the Board~~

~~_____~~

~~Vice Chair — Independent Member of the Board~~

Attendees

~~4.2— In attendance — Executive Director of OD and Workforce~~

- _____ Deputy Director of (WBS) or SMT Representative
- _____ Director of Operations (VCC) or SMT Representative
- _____ Medical Business Manager (VCC)
- _____ Clinical representative to be identified by the
_____ Medical Director
- _____ Nursing representative
- _____ Therapies representative
- _____ Scientific Representative
- _____ Assistant Director of Workforce
- _____ Assistant Director of OD and Modernisation
- _____ Senior Workforce and OD Business Partners (VCC and
WBS)
- _____ Workforce and OD Manager (NWIS)
- _____ Welsh Language Officer
- _____ Workforce Development Manager
- _____ Head of Corporate Governance
- _____ 2 Staff Representatives (nominated by staff
members of Local Partnership Forum)
- By Invitation _____ The Committee Chair may extend invitations to attend
Committee meetings as required to the following:
- _____
- any other Trust officials; and / or any others from
within or outside the organisation to attend all or
part of a meeting to assist it with its discussions on
any particular matter.

_____ **Secretariat**

4.3 _____ As determined by the Director of Corporate Governance.

_____ **Member Appointments**

4.4 _____ The membership of the Committee shall be determined by the Board, based on
the recommendation of the Trust Chair – taking account of the balance of skills
and expertise necessary to deliver the Committee’s remit and subject to any
specific requirements or directions made by the Welsh Government.

~~4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee with reference to Velindre NHS Trust Chair.~~

~~Support to Committee Members~~

~~4.6 The Director of Corporate Governance on behalf of the Committee Chair, shall:~~

- ~~• arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and~~
- ~~• ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.~~

5. COMMITTEE MEETINGS

~~Quorum~~

~~5.1 At least 2 members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.~~

~~Frequency of Meetings~~

~~5.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Committee deems necessary — consistent with the Trust's Board Cycle of Business.~~

~~Withdrawal of individuals in attendance~~

~~5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.~~

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

~~6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.~~

~~6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.~~

~~6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:~~

- ~~joint planning and co-ordination of Board and Committee business; and~~
- ~~sharing of information~~

~~in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.~~

~~6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.~~

~~6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.~~

~~7. REPORTING AND ASSURANCE ARRANGEMENTS~~

~~7.1 The Committee Chair shall:~~

- ~~report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports throughout the year;~~
- ~~bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;~~
- ~~ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.~~

~~7.2 The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation.~~

~~7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.~~

~~8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS~~

~~8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:~~

- ~~Quorum — as per section 5.1 above~~

~~Cross reference with the Trust Standing Orders.~~

~~9. REVIEW~~

- ~~9.1 — These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.~~

~~10. CHAIR'S ACTION ON URGENT MATTERS~~

- ~~10.1 — There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.~~
- ~~10.2 — Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.~~

WELSH HEALTH SPECIALISED SERVICES COMMITTEE JOINT COMMITTEE MEETING – OCTOBER 2020

The Welsh Health Specialised Services Committee held its latest public meeting on 13 October 2020 with a 'consent agenda', as described on the WHSSC website. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

<https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2020-2021-meeting-papers/>

Reducing harm due to COVID-19: Stereotactic Ablative Radiotherapy and Brachytherapy

Members received a paper that requested approval for in-year funding to expand the commissioned indications for Stereotactic Ablative Radiotherapy (SABR) and Brachytherapy in order to provide additional, evidence based, treatment options to support the reduction of harm related to the COVID-19 pandemic.

Members (1) noted that clinical evidence favours the routine commissioning of SABR to treat patients with Oligometastatic cancer and Hepatocellular carcinoma; (2) noted treating patients with SABR helps to reduce COVID related harm since the relative benefits of SABR compared with alternative treatment modalities (surgery or systemic therapy) increase when there is risk of infection with COVID-19; (3) noted clinical evidence favours the routine commissioning of Brachytherapy to treat patients with intermediate and high risk localised prostate cancer; (4) noted by substituting for a proportion of external beam radiotherapy, the provision of brachytherapy for intermediate and high risk prostate cancer patients will allow increased radiotherapy throughput, reducing COVID related harm by increasing the ability to treat backlog and manage any future surge of previously suppressed demand; (5) approved commissioning SABR for patients with Oligometastatic cancer and Hepatocellular carcinoma in line with WHSSC's draft commissioning policies as in-year service developments on an interim basis for 6

months; (6) approved commissioning Brachytherapy in line with WHSSC's draft commissioning policy as an in-year service development on an interim basis for 6 months; and (7) noted recurrent funding for SABR for Oligometastatic cancer and Hepatocellular carcinoma, and Brachytherapy for intermediate and high risk prostate cancer, will be considered through the WHSSC ICP process for 2021-24.



TRUST BOARD

GOVERNANCE ARRANGEMENTS DURING COVID UPDATE: FINAL REPORTS FOLLOWING AUDIT WALES AND INTERNAL AUDIT ADVISORY JOINT REVIEW

DATE OF MEETING	26 th November 2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Rebecca Goode, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance

REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	05/10/2020	NOTED
Audit Committee	8/10/2020	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

- 1.1 Trust Board were informed at the 25th June 2020 meeting that Audit Wales and Internal Audit would undertake a combined audit review to form an opinion on how the Trust has adapted and operated during the COVID-19 pandemic in respect of governance and decision making.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The work was structured under the following themes:-

Audit Wales

- Leadership and Governance;
- Financial Management;
- Operational Planning

Internal Audit

- Governance and risk management;
- Delegation and escalation; and
- Departures from existing policies and processes

The final reports are attached and overall the Trust was found to operate effectively throughout COVID-19. It demonstrated a strong culture of good governance based on transparency, collaboration and constructive challenge.

To confirm that there were no recommendations but some considerations for the Trust going forward.

Appendix 1 – Structured Assessment Final Report – Key messages outlined on page 5 of the report.

Appendix 2 – Governance Arrangements during the Covid-19 Pandemic – Main observations and priority considerations for the future outlined on page 4/5 of the report.

3. IMPACT ASSESSMENT



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
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 Trust Board are asked to **NOTE** the contents of both reports and the key message that confirm that the Trust operated effectively during the peak of the pandemic.

Structured Assessment 2020 – **Velindre University NHS Trust**

Audit year: 2020

Date issued: September 2020

Document reference: 1963A2020-21

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

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Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2020 structured assessment work at Velindre University NHS Trust (the Trust). The work has been undertaken to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2014, to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.
- 2 This year's Structured Assessment work took place at a time when NHS bodies were responding to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. On 13 March 2020, the Minister for Health and Social Services issued a framework of actions to help prepare the system for the expected surge in COVID-19 cases. The framework included the cessation of non-urgent planned activity and the relaxation of targets and monitoring arrangements across the health and care system. Emergency funding arrangements were also introduced to facilitate the wide range of actions needed to respond urgently to the COVID-19 pandemic.
- 3 Shorter planning cycles were agreed for 2020-21 and supported by quarterly guidance setting out key considerations for the planning of the next phase of the pandemic, for maintaining delivery of essential services, and a movement towards the gradual reinstatement of routine services.
- 4 Our work was designed in the context of the ongoing response to the pandemic to ensure a suitably pragmatic approach to help the Auditor General discharge his statutory responsibilities whilst minimising the impact on NHS bodies as they continue to respond to the next phase of the COVID-19 pandemic¹. The key focus of the work is on the corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Auditors also paid attention to progress made to address previous recommendations² where these related to important aspects of organisational governance and financial management especially in the current circumstances.
- 5 The report groups our findings under three themes:
 - governance arrangements;
 - managing financial resources; and
 - operational planning: to support the continued response to the pandemic balanced against the provision of other essential services.
- 6 The Trust hosts three organisations, Health Technology Wales, the NHS Wales Shared Services Partnership (NWSSP) and the NHS Wales Informatics Service

¹ Our work was co-ordinated with Internal Audit's rapid governance review which includes further testing of key controls noted in this report.

² Previous recommendations can be found in our [2019 report](#).

(NWIS). There are differing hosting and Trust governance arrangements for each organisation. This report focuses on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively and economically. We have not reviewed these arrangements for NWIS or NWSSP.

Key messages

- 7 Overall, we found that the Trust continued to operate effectively throughout COVID-19. It is building a strong culture of good governance based on transparency, collaboration and constructive challenge. The Trust adapted its governance, quality, safety and risk management arrangements quickly and continues to identify opportunities to improve.
- 8 The Trust and its Board have worked well under pressure to adapt governance arrangements. Business is shared effectively between the Board, Audit Committee and Quality and Safety Committee. Board business is transparent and well communicated. Information flows effectively from the Trust's executive team to the Board and the Board is clearly central to decision making. Board members provide good scrutiny and there is mutual respect between Board members. The Trust continues to review and refine its governance and corporate arrangements and look for ways to improve. The Trust has good arrangements to ensure safe, quality services and to manage risk. It continues to provide good information to assure the Board and its Committees of the quality and safety of its services.
- 9 The Trust's arrangements for managing financial resources are working well. It met its financial duties to break even over the financial year 2019-20 and the three - year rolling period 2017-18 to 2019-20. The Trust continues to forecast breakeven in 2020-21 although achieving financial balance assumes additional funding will be made available to cover the ongoing costs of responding to COVID-19. It has strong financial controls and provides clear information on financial performance and risk for Board scrutiny.
- 10 The Trust quickly developed operational plans as required by the Welsh Government. It is continually identifying the resources needed to deliver the plans and assessing the unknown implications of the pandemic. The Trust has identified risks to implementing its plans, including the resource implications of restarting services. The Board has been involved with developing the plans and has agreed arrangements to monitor progress. The Trust engaged stakeholders to develop and implement its plans but would benefit from earlier engagement with the Community Health Council (CHC) to inform future plans.
- 11 We have not made any new recommendations based on our 2020 work but have noted improvement opportunities throughout this report. We will review progress against these and outstanding 2019 recommendations as part of our 2021 work.

Detailed report

Governance arrangements

- 12 Our structured assessment work considered the Trust's ability to maintain sound governance arrangements while having to respond rapidly to the unprecedented challenges presented by the pandemic. We also reviewed the progress made in addressing our previous recommendations.
- 13 We found that **the Trust adapted governance arrangements and how it manages risk and maintained systems of assurance during its response to the first phase of the pandemic and is making progress towards longer-term improvements.**

Conducting business effectively

The Trust adapted governance arrangements to maintain transparency, support agile decision-making and ensure effective scrutiny during the response to COVID-19

The Trust conducts business in an open and transparent way

- 14 Whilst unable to conduct its meetings in public, the Trust's Board moved quickly and effectively to virtual Board and committee meetings. Board papers are published in advance of meetings³. Since March 2020, Board meeting minutes have generally been published within a few days of meetings. Despite good intentions, some Board meeting minutes were not published until confirmed two or three weeks after the meeting. In June 2020, the Trust trialled video recording the Board meeting, and live streamed its first Board meeting in July 2020.
- 15 Our observations of Board meetings found that meetings have been effective with attendees abiding by good meeting etiquette, and opportunities provided to ask questions and comment. There are back-up plans in place should there be problems with IT systems.
- 16 The Trust has continued to engage well with stakeholders, including meeting weekly with local partnership forum members and trade union representatives. Patient advocates from the CHC have attended each Board meeting and provided their views on service changes. During the initial response stage of the pandemic, several service changes were implemented without much opportunity to discuss the changes with the CHC.
- 17 In our 2019 structured assessment report, we outlined positive changes to strengthen and increase the capacity of the senior management structure. Whilst these arrangements were still embedding at the time the pandemic took hold,

³ The Trust completed our 2018 recommendation to ensure board papers are available to the public in advance of board meetings.

executive responsibilities during the response phase have been clear and balanced.

- 18 In March 2020, the Trust implemented its major incident plan and incident management structure to ensure agile and rapid decision making during the pandemic. Led by the Chief Executive, Gold Command Group was responsible for strategic decision making. Gold Command Group was supported by five supporting command groups. Silver Command Group was led by the Chief Operating Officer and responsible for tactical decisions. Separate Bronze Command groups for Velindre Cancer Centre (VCC), the Welsh Blood Service (WBS), support services and Trust headquarters were responsible for making operational decisions. Each command group had defined accountabilities and received information and advice from supporting clinical groups. The Board agreed a decision-making framework and supporting impact assessment process to determine which command group should be responsible for individual decisions. The framework also set out the process for escalating and de-escalating issues arising. Each command group initially met daily, although the frequency reduced to twice weekly in April, reflecting the maturation of the Trust's preparatory activity. At the end of May 2020, the Trust stood down the incident management structure and responsibilities were incorporated into the standard executive management arrangements.
- 19 The Trust commissioned 'cells' to ensure timely, proportionate and co-ordinated Trust-wide management of cross-cutting and critical elements of the COVID-19 response⁴. Each cell is led by an executive officer. Once intended outputs are delivered or the systems set up by the cell are embedded into existing arrangements, individual cells will be stood down. The cells' work has been shaped and focused by principles developed for VCC and WBS outlining the new ways of working, paused activity and ways of assessing patients and mitigating risk.
- 20 As has been the case in previous years, our observations of Board and committee meetings found that executive officers actively seek opportunities to involve the Board's Independent Members (IMs) and have maintained an open, transparent relationship.

Revised governance arrangements have supported Board scrutiny during the COVID-19 response

- 21 In March 2020, the Board agreed that it should focus on maintaining effective oversight and scrutiny. Board meetings have been held each month, an increase from every other month. The Board's committee/partnership forums were stood down for an initial period of six months, with the following exceptions:

⁴ Seven cells were established at the end of April 2020: quality and safety; personal protective equipment (PPE); end of life and death procedures; workforce; digital; planning; and information/performance. In May 2020, two additional cells were established: social distancing; and test and trace.

- the Quality and Safety Committee has met each month and plans to do so until September 2020, when meeting regularity will be reviewed;
 - the Audit Committee and NHS Wales Shared Services Partnership Audit Committee (NWSSP Audit Committee) have met as previously scheduled but meeting dates moved to accommodate the changes in final accounts reporting timescales; and
 - the Transforming Cancer Service Programme Scrutiny Committee has continued to meet as previously scheduled to make critical pathway decisions for the Transforming Cancer Service (TCS) programme⁵.
- 22 The required variation to the Board's Standing Orders was scrutinised and approved by the Audit Committee on 21 April 2020 and the Board on 30 April 2020. Scrutiny, assurance and decision-making responsibilities for those committees stood down were delegated to the Board or a sitting committee.
- 23 The corporate governance team reviewed the committees' programme of business. The review considered which items should be managed/tracked and allocated to a sitting committee, closed by an out-of-committee chair action, or paused and placed in the recovery log. The recovery log is a formal record of items to be continued at a more appropriate time and was presented to each Board meeting. At the June Board meeting, it was confirmed that recovery log items were beginning to be brought back into active management with appropriate scrutiny arrangements. The Trust also developed a central log of external postponed activities and provided it to the Board.
- 24 Board and committee programmes of business were revised to focus on business-critical matters. Best use of board and committee meeting time has been maintained by adding agenda items to the consent agenda⁶, where appropriate to do so. Board members are always given the opportunity to move items from the consent agenda if they feel it is necessary to discuss the item. In addition, board briefings have been used to provide background information about items discussed at Board, to allow formal Board meetings to focus on scrutiny and challenge. Board members received weekly briefings in April (decreasing to fortnightly briefings in May) ensuring all IMs were fully briefed on the Trust's response to the pandemic and the associated issues and risks. The Chair has had daily meetings with the Chief Executive Officer, and regularly attended Gold Command Group meetings to provide a Board view to discussions. The Chair has also held regular briefings with the IMs in relation to pandemic response.

⁵ The TCS programme aims to meet the increasing demand and complexity of cancer care and to deliver more care closer to home. There are a few strands to the programme, the key one being the construction of a new cancer centre.

⁶ A consent agenda is a board meeting practice that groups routine business and reports into one agenda item. The consent agenda can be approved in one action, rather than filing motions on each item separately.

- 25 During our fieldwork we found a consistent understanding of the revised arrangements amongst board members. We also found effective scrutiny and challenge at Board and committee meetings. Meeting minutes provide a detailed summary of board and committee deliberations, including verbal reports.
- 26 Two independent members (IMs) joined the Trust at the end of 2019 and have quickly developed knowledge, skills and confidence. The Trust is seeking approval for the extension of the term of one IM whose appointment is due to end in autumn 2020. Suitable IM cover arrangements were established to ensure quoracy was maintained despite the increased meeting regularity. IMs have been proactive and flexible in their approach including attending more frequent meetings and digesting huge amounts of information.

Information received by the Board is supporting scrutiny

- 27 Papers for Board and committee meetings have been provided in advance of meetings, allowing adequate time for scrutiny. Due to the rapid changing environment, on occasions papers were amended at short notice before meetings. However, verbal confirmation of changes was provided. Board and committee papers are concise and informative, whilst ensuring the Board and committees have the required information to make decisions. Assurance from committees to the Board has continued to work well through committee chair reports at every Board meeting.
- 28 Verbal presentations by officials at Board and committee meetings are usually very good, with clear summaries of often complex information, drawing attention to key issues and areas of concern. We have observed a transparent and explicit approach to the declaration and handling of conflicts of interest.
- 29 Where Chairs' actions have been necessary, for example for NWSSP expenditure on all-Wales provisions, such as personal protective equipment (PPE), ventilators and beds, there is a log of the decision, evidence of IM scrutiny and subsequent ratification by the Board.
- 30 Decision logs have also been created and maintained to record all decisions made by the incident management structure, and separately to record COVID-19 related expenditure. A log was established to track compliance with Welsh Government guidance and legislation relating to COVID-19. Both the expenditure and legislation logs have been shared with the Board for noting, as has a summary of each decision made by the Gold Command Group.
- 31 The Trust has updated a range of policies in response to COVID-19. Revisions clearly identify interim COVID-19 arrangements, and policies have been approved by the Board or a committee. In June 2020, the Trust reported it would review all 150 policies by the end of July 2020 to ensure each remains fit for purpose in the context of COVID-19. It is intended that all policies and their associated approval

mechanisms will be added to a repository register⁷, with necessary interim amendments actioned.

The Board continues to demonstrate a commitment to learning and continuous improvement

- 32 Board and committee meetings continue to provide an opportunity to reflect and feed back on meeting conduct. The Board has considered the effectiveness of the revised corporate governance arrangements for Board and committee business during the pandemic. Rather than return to pre-COVID-19 committee arrangements, the Board has plans to approve a new improved and streamlined committee structure in September 2020 for implementation in October 2020.
- 33 More broadly, Board members want to ensure that the Trust can learn from and adopt positive organisational changes made during the pandemic. At the time of writing, the Trust was holding sessions to capture and learn from the ways of working implemented by the incident management structure and the Board (between March and July 2020). Several themes have been identified, including the improved clarity of decision-making responsibilities, agility of decision making, continued improvement of people practices and enhanced digital connectivity. Where relevant, these themes are being considered alongside existing improvement projects, including the integration of some divisional support functions and the continuing development of leaders and managers.

Managing risk

The Trust has effectively adapted its risk management system to identify and manage new COVID-19 related risks and is making good progress towards longer-term improvements

- 34 In our 2019 structured assessment, we highlighted that the Board had agreed an interim Board Assurance Framework (BAF)⁸ in November 2019. We recommended that the Trust should complete and expedite the development of its full BAF with an underpinning up-to-date risk management framework. In previous reports we have also recommended that the Trust should standardise the format of its various risk registers and ensure that the risks relating to the delivery of strategic priorities are included in the corporate risk register (CRR).
- 35 In January 2020, the Trust set out its plans to complete the development of the BAF, risk appetite, CRR and risk management framework by June 2020. Whilst the

⁷ The Trust had previously identified that there was no central repository for the management and document control of Trust policies.

⁸ A key document for recording and reporting the risks to achieving strategic priorities, the controls needed to mitigate against risks, sources of assurance, responsible executive officers and committee scrutiny arrangements.

Trust has continued to make good progress through 2020, the completion date has been extended until the end of October 2020 to focus on COVID-19 governance. The Board and Audit Committee have been kept informed of progress to date. Work to develop a new BAF template has continued. The Trust plans to identify strategic risks aligned to operational plans and the Trust long-term strategy currently in development. The intention is to add all identified strategic risks to the BAF with associated controls, sources of assurance, responsibilities and committee scrutiny arrangements. It is also intended that qualifying strategic risks will be added to the CRR.

- 36 The Trust undertook a review of all operational risks on divisional risk registers in January 2020. The review considered the suitability and consistency of risk scores, mitigating controls and escalation arrangements prior to migrating all risks to an upgraded risk module in Datix⁹. Work is progressing to standardise divisional and hosted body risk registers, and to ensure that escalation arrangements are working as required. The Trust plans further work to improve the description of risk and clarity of mitigating controls and sources of assurance (and their effectiveness) in risk registers, and to ensure that risk registers reflect the new risk management framework requirements.
- 37 Work is also progressing to refresh the risk appetite statement with accompanying guidance on how to apply risk appetite to mitigating actions for managing operational and strategic risks.
- 38 The development of the risk management framework is running concurrently with the development of the refreshed BAF, CRR and risk appetite statement. The initial outputs of all strands of work will be considered by Executive Management Board and by the Board during summer 2020, with Board sign-off planned for October 2020. The Trust is considering how risk management training will be rolled out to staff.
- 39 It is too early to comment definitively on the developing risk arrangements, but the work completed to date along with planned developments indicates a positive direction of travel. The Trust is also recommencing work to refresh the performance management framework and quality governance framework. Once developed, they will be brought together with the risk management framework into an overarching integrated governance framework.
- 40 In response to COVID-19, in April 2020, the Trust impact assessed all risks on the Trust CRR to enable the management of critical risks to be prioritised. All risks on the CRR that would normally be scrutinised by a committee stood down during COVID-19 have been mapped to a sitting committee for scrutiny. A small number of risks were paused where their relevance was temporarily superseded by the

⁹ Datix is a web-based incident reporting and risk management system used by healthcare organisations.

COVID-19 response¹⁰. New COVID-19 risks are flagged. Between April and May, critical risks were managed through the incident management command structure with appropriate escalation arrangements in place. Since June, standard escalation arrangements to Executive Management Board have applied. Any COVID-19 risk scoring 12+ is escalated to the CRR¹¹ for Board consideration. The Board has been closely involved in developing and overseeing the Trust's approach to managing strategic and operational risks associated with COVID-19. The CRR is scrutinised and challenged at Board and both Audit Committee and Quality and Safety Committee.

Systems of assurance

Assurance systems have been maintained during the pandemic enabling strong assurance to the Board and its committees

The Trust has maintained focus on requisite quality and safety during COVID-19, with key assurances provided to the Board and Quality and Safety Committee

- 41 Since March, the Board and the Quality and Safety Committee have received a monthly COVID-19 update report setting out the latest developments and changes to service delivery. The Quality and Safety Committee has also received:
- dashboard reports of COVID-19 cells (quality and safety, PPE, end of life procedures, workforce, planning, social distancing and test and trace). Reports provide summaries of actions completed, actions to be completed, and key risks/issues.
 - a summary of the decisions made by the Gold Command Group when it still met.
 - highlight reports of topics normally considered by the Quality and Safety Committee, but with adaptations to consider and reflect COVID-19 assurances.
 - new quality and safety reports for both VCC and WBS covering key updates and issues (not reported in existing highlight reports)¹², including reporting on the impact of COVID-19 on the quality and safety of services.

¹⁰ For instance, risks relating to radiotherapy capacity and overcrowding of the outpatient department at VCC were paused to be considered as part of demand and capacity planning within the recovery phase.

¹¹ Normally only risks scoring 16+ are escalated to the CRR.

¹² The introduction of this report will help to ensure regular, cyclical reporting and consideration of key aspects of quality and safety, which previously were considered on an ad hoc basis.

- 42 The Quality and Safety Committee considered whether it was receiving adequate assurance in each of the areas set out in the Welsh Government guidance on **Discharging Board Committee Responsibilities during COVID-19 response phase**, and arrangements were made to fill gaps in reporting.
- 43 In previous structured assessment reports, we have made recommendations on addressing weaknesses in the scrutiny of clinical audit planning and reporting. As a result of the pandemic, the target date for completing actions to address recommendations has been postponed to October 2020. The Trust has, however, established a Quality Improvement Hub comprised of a multidisciplinary panel to consider the feasibility of clinical audit projects and ensure appropriate governance arrangements are in place. A Trust-wide clinical audit plan was approved by the Quality and Safety Committee in July 2020. The plan sets out national and local programmes of clinical audit work, which will be prioritised and restarted when appropriate to do so. The plan also identifies COVID-19 related clinical audits (relating to infection control and the implications of changes to treatment plans). It is intended that clinical audit will form a key part of the developing integrated governance assurance framework, which will help to strengthen monitoring of the quality of services across the Trust. In addition, there are plans to refocus quality assurance in WBS to support change and improvements rather than on just inspection and enforcement.
- 44 The Quality and Safety Committee has continued to scrutinise reports on investigations into complaints and incidents. Reports identify trends, potential areas of concern, and the action taken to share learning across the organisation. The committee received the annual **Putting Things Right** report in July 2020. Committee reports also set out the Trust's process for investigating hospital acquired COVID-19 infections amongst both patients and staff¹³. The Quality and Safety Committee has received assurances that the Trust has appropriate reporting mechanisms to comply with reporting of COVID-19 serious incidences, and the notification of deaths suspected to be related to COVID-19. Mortality reviews continue to be undertaken and reported to the Quality and Safety Committee.
- 45 The Quality and Safety Committee received assurance from the End of Life cell that VCC complied with relevant guidance on end of life care and care of the deceased. Arrangements are in place for the ongoing staff communication and monitoring in relation to the guidance. The End of Life cell has also led on ensuring appropriate bereavement support for next of kin and ensuring that visiting arrangements align with national requirements.
- 46 The Trust continues to monitor compliance with patient safety alerts and notices and to report quarterly to the Quality and Safety Committee.

¹³ The Trust has developed processes for reporting and investigating patient and staff acquiring COVID-19, which have been incorporated into a national approach.

- 47 The Trust's Infection, Prevention and Control Management Group has met at least monthly throughout the pandemic. The Quality and Safety Committee has received assurance on the enhanced cleaning regimes put in place. Findings of hand hygiene compliance and cleaning standards reviews have been reported to the Quality and Safety Committee, with a clear summary of actions either already implemented or underway to improve compliance.
- 48 The PPE cell's dashboard has been reported to the Quality and Safety Committee, providing a summary of the key headline message and actions completed and currently underway. The dashboard information has provided assurance to the Board on levels of PPE stock, usage rates, compliance with fit testing of masks and compliance with donning and doffing of PPE.
- 49 Reports from the social distancing cell provide a summary of measures implemented in VCC, at WBS sites and the Trust headquarters to limit the spread of infection and comply with social distancing requirements.
- 50 Clinical decisions to defer or to change cancer treatments have been made under a Clinical Governance and Operating Framework (Clinical/ Patient pathway/ Treatment Decision Making During COVID-19). The Board approved the framework in March 2020 and again in May when it was updated. The Board has been kept up to date with changes to patient treatment pathways and deferred care. A report to the June 2020 Quality and Safety Committee provided assurance that there were no essential services unable to be maintained. Risk assessments are carried out and considered before making decisions on changes to service delivery or the reinstatement of services. Decisions on service changes are informed by the Welsh Government and other relevant guidance.
- 51 Committee reports indicate that the Trust is working to identify the risk of harm to patients. Performance reports provide a summary of performance against waiting times and a summary of reasons and impact on patients. The Trust has established a multidisciplinary Clinical Touchpoint Group to provide support to clinical teams in developing clinical prioritisation and impact assessment processes. A review of all patients whose care was deferred during the pandemic is scheduled for completion by September 2020. At this time, patients will be moved on to an appropriate treatment pathway, and the impact and harm of deferred treatment will be identified and captured. Future reporting will need to focus on the outcomes.
- 52 We previously reported on the Trust's comprehensive and proactive approach to staff health and wellbeing. During the pandemic, the Quality and Safety Committee has received regular assurances on the Trust's approach to staff wellbeing and steps to protect staff during the pandemic. The Trust is working in partnership with trade unions and staff representatives to understand staff concerns, to develop and issue surveys and implement communication campaigns around the importance of risk assessment for vulnerable staff. In **paragraph 85** we have provided more information about the wellbeing initiatives for staff. Trust staff also developed several excellent publicly available videos explaining how the pandemic has

affected the way they work, and to give reassurance to patients and donors about the safe continuation of services.

- 53 The Trust developed a workforce risk assessment tool to assess staff who are vulnerable or at increased risk of contracting coronavirus, including people from BAME backgrounds, and subsequently incorporated the All-Wales toolkit. Staff are encouraged to complete their self-assessments and return them to their manager. At the June 2020 Quality and Safety Committee meeting, the Trust reported that 97% of staff had completed the risk assessment. Different arrangements exist for staff identified as at higher risk, including homeworking, higher levels of PPE and where appropriate medical exclusion.
- 54 The Trust developed a COVID-19 workforce dashboard to monitor recruitment, deployment, PPE training compliance, absence, staff testing, risk assessments and ensuring safe staffing levels. The Quality and Safety Committee and Board also receive workforce metrics, including COVID-19 related absences, those who are shielding or self-isolating.

Tracking of progress against audit recommendations has continued

- 55 The Trust has a well-established approach for tracking progress against audit recommendations. The Audit Committee has continued to review the internal and external audit tracker at each meeting. In our 2019 report we recommended that the Audit Committee should establish a mechanism to satisfy itself that actions taken were satisfactory to remove recommendations from the tracker. Work continues to address this recommendation.
- 56 The July 2020 audit tracker highlighted the actions where extensions to implementation dates had been requested due to COVID-19. The extension requests were approved by the Audit Committee. We noted that some actions that had missed the completion deadline omitted a recent update and a request for an implementation extension. For these actions the Audit Committee set an appropriate completion deadline and escalated the requirement to provide this information in the Audit Committee highlight paper to Board.
- 57 The Quality and Safety Committee external and internal audit improvement tracker has been embedded over the last 12 months. The June 2020 tracker provided assurance that actions had been implemented to close most recommendations. For those actions in progress or overdue, a revised completion date was provided, due to the inability to meet the original deadlines as a direct consequence of responding to the pandemic.

Managing financial resources

- 58 Our work considered the Trust's financial performance, changes to financial controls during the pandemic and arrangements for monitoring and reporting financial performance.
- 59 We found that **the Trust's arrangements for managing financial resources are working well but they assume additional funding to cover the ongoing cost of responding to COVID-19.**

Achieving key financial objectives

The Trust continues to meet its financial duties but financial plans for 2020-21 assume additional funding to cover the ongoing cost of responding to COVID-19

The Trust continues to meet its financial duties

- 60 The Trust consistently achieves financial balance and, in 2019-20, reported a small surplus of £24,000. The Trust also achieved its statutory financial duty to achieve break-even over a rolling three-year period (2017-18 to 2019-20). The Trust secured an approved integrated medium-term plan (IMTP) for the period 2019-20 to 2021-22. The year-end position included £80,000 of costs related to the Trust's response to COVID-19. Of these additional costs, £46,000 of capital expenditure was funded by the Welsh Government, and the remaining £34,000 of revenue expenditure was managed within the Trust's year-end position¹⁴.
- 61 In 2019-20, the Trust established a savings requirement of £1.833 million, of which £1.504 million was to be delivered from identified savings schemes and income generation with the remaining £0.329 million to be met by additional income targets and accountancy gains. The Trust delivered 93% of its planned savings schemes, delivered the intended income targets and accountancy gains, but made further savings through holding open vacancies. Therefore, overall, the Trust delivered £1.594 million (106%) of planned savings, of which 72% are recurrent.

The Trust's programme of work for 2020-21 is underpinned by a financial plan but achieving financial balance assumes additional funding will be made available to cover the ongoing cost of responding to COVID-19

- 62 The Trust's financial plan for 2020-21, set out in the IMTP, was shared with the Board in January 2020. The plan identifies that savings of £1.4 million (£0.8 million

¹⁴ Considerable additional expenditure relating to COVID-19 was incurred by NWIS and NWSSP, but does not fall within the scope of our review.

of actual savings and £0.6 million of income generation schemes) are required to achieve break-even. The savings target is set in the context of;

- offsetting the underlying deficit brought forward from 2019-20 (£0.539 million);
- covering £1.517 million of new cost pressures and investments to fund changes set out in the IMTP; but
- recognises a new recurring income allocation of £0.656 million. The identified savings comprised £1 million of actual savings and £0.4 million of income generation schemes.

- 63 Since March 2020, the Trust has revisited and adapted its financial plans. It is a challenge to develop definitive plans given numerous unknown factors regarding the impact of the pandemic. Uncertainties include the ability to make savings and realise income, the unknown quantum of additional Welsh Government funding to fund COVID-19 costs and uncertainties around commissioning health board fees.
- 64 At month 2, detailed savings plans had been developed for £1.05 million of the target. However, £0.35 million of savings schemes were still in development and needed to be risk assessed in terms of achievability and service impact. A significant proportion of the savings were expected to be delivered through service redesign and workforce rationalisation, which the Trust has not enacted due to the capacity needs of delivering during the pandemic. The Trust also anticipates the likelihood of achieving intended income from an increase of blood products to be low. As at month 3, the Trust reported that it anticipates that only £0.7 million (50%) of the full-year savings and income generating target is considered achievable. Month 3 plans show there are detailed savings plans of £0.65 million (a reduction of £0.4 million from the previous month), £0.05 million of plans in development and the remaining £0.7 million of savings unlikely to be delivered. Month 3 year-to-date savings have underachieved by £0.139 million.
- 65 Over the last couple of years, the Trust has been working towards introducing a new financial costing model. The model is based on new contract currencies (activities) and prices that better reflect the range and complexity of the specialist cancer services provided by VCC. The model is sufficiently flexible to accommodate treatment changes over time. As well as agreeing new prices based on time-driven activity-based costing, more realistic marginal rates for variances in contracted volumes have also been agreed with the commissioners. The Trust aimed to implement the model in 2020. However, reduced levels of activity during the pandemic mean the Trust and commissioners agreed a revised approach for the first half of 2020-21 to ensure the Trust's financial stability. For the first half of 2020-21, the Trust's income from VCC commissioners was based on the 2019-20 outturn plus agreed baseline uplifts for 2020-21. There is uncertainty over the agreement of funding levels for the second half of the year, as no agreement has been reached. At the time of writing, the Trust is planning on a neutral impact regarding marginal activity income due to the complexities and uncertainties around forecasting future activity levels.

- 66 At month 3, the Trust reported that the total forecasted expenditure on COVID-19 for 2020-21 is expected to be £3.354 million with the potential for further investment of £4.684 million to increase capacity later in the year should demand reach pre-COVID-19 levels of activity. Thus, total costs could amount to £8.038 million. This has increased significantly from previous forecasts due to the inclusion of the potential further investment of £4.684 million. The total includes £2.438 million in pay costs, £5.150 million in non-pay costs and £0.7 million in non-delivery of savings. However, the Trust anticipates a reduction of £0.25 million in costs. The non-pay expenditure forecast includes £1.153 million relating to an all-Wales convalescent plasma service, which the Welsh Government has agreed to fund.
- 67 Therefore, as of month 3, the unfunded forecast revenue expenditure for COVID-19 could amount to £6.885 million if demand were to reach pre-COVID-19 levels. The year-to-date expenditure on COVID-19 is £0.764 million. At month 3, the Trust reported a small overspend of £13,000, with a significant underachievement against income offset by an underspend in both pay and non-pay. The Trust is currently working to the assumption that full costs and any savings that are directly affected by COVID-19 will be fully funded by the Welsh Government.
- 68 At month 3, the Trust's approved capital funding for 2020-21 totalled £4.992 million. This represents all-Wales capital funding of £2.653 million and £1.850 million of discretionary capital and confirmed COVID-19 funding from the Welsh government of £0.489 million. The Trust is forecasting to spend £1.457 million on COVID-19 related capital expenditure during 2020-21. A submission was made to the Welsh Government in June requesting funding to support these costs. The Trust has since received confirmation of funding of £92,000 for digital devices and £0.397 million on convalescent plasma collection devices. At month 3, capital expenditure was in line with planned expenditure, excepting that relating to COVID-19. The Trust is developing discretionary capital schemes that will be ready to proceed once the Trust receives confirmation of funding from the Welsh Government on both COVID-19 and TCS programme funding. Discretionary funding has been allocated to both divisions to allow urgent digital schemes to progress.
- 69 The TCS Programme is primarily funded from a separate capital budget allocation provided by the Welsh Government. Capital requirements are outlined in the formal business cases that have been submitted to the Welsh Government. Whilst awaiting the approval of the business case, the Trust has submitted an interim request for funding of £1.1 million for the period April to September 2020 and, until a decision is made, is using discretionary funding to support the TCS programme.
- 70 The Trust has submitted the monthly monitoring returns to the Welsh Government in line with the new templates. The financial position is reported to Board each month, although full reports were not received in March and April. Our review of financial reports reported to Board in May to July found they provide high-quality and timely information on financial performance, including financial savings and cost drivers related to COVID-19. Finance reports also clearly identify financial risks and cost implications.

Financial controls

Mechanisms exist for accurately recoding and tracking COVID-19 expenditure and the Trust made necessary changes to financial controls

- 71 The Trust's financial governance arrangements are largely unchanged except for approved changes to delegated limits for the Trust Chief Executive and NWSSP's Chair and Managing Director. A temporary increase in the Chief Executive's delegated limit enables him to commit financial resources of up to £1 million for COVID-19 related activity only (an increase of £900,000). The delegated authorisation limit for NWSSP's Chair and Managing Director was lifted to £2 million and subsequently to £5 million in respect of COVID-19 expenditure incurred on behalf of NHS Wales (for PPE, beds, ventilators and oxygen). An NWSSP Finance Governance Group was established on behalf of NHS Wales to oversee expenditure that required payments in advance and/or approval by the Trust Board. The Trust's vice-chair sits on this group, enabling the Trust's governance responsibilities for NWSSP expenditure to be considered. The requirement to notify the Welsh Government of the Trust's and its hosted bodies' intent to enter a contract over £1 million or where advance payments were worth 25% or more of the contract value remain in place.
- 72 The Board also approved suspending the requirement to follow the Standing Financial Instructions' procurement thresholds related to competitive tenders and quotes during the COVID-19 emergency, which is permissible under current procurement regulations. The Trust's Audit Committees continue to receive Trust, NWIS and NWSSP reports on Single Tender Actions (STAs) and Single Quotation Actions (SQAs) as required in the SFIs. There have been no prepayments made by the Trust during COVID-19, other than those relating to All Wales purchases by NWSSP. The NWSSP Audit Committee has received reports containing details of purchases where an advance payment was required, and reports of All Wales related COVID-19 expenditure. Escrow¹⁵ accounts were set up for new suppliers and where upfront payments were required.
- 73 The Trust set up separate cost codes to capture COVID-19 related expenditure in each directorate to which all agreed revenue expenditure should be coded. Mechanisms exist to ensure that expenditure coded to COVID-19 is appropriate, and that expenditure is within delegated budgets. The Trust has maintained decision logs relating to COVID-19 financial expenditure. Expenditure relating to COVID-19 is included on the monthly monitoring returns to the Welsh Government and reported to Board.

¹⁵ Escrow is a financial arrangement in which two parties enlist a third party to temporarily hold money, paperwork or assets for a transaction on their behalf before the transaction has been finalised.

Operational planning

- 74 Our work considered the Trust's progress in developing and delivering quarterly operational plans to support the ongoing response to COVID-19 and to provide other essential services and functions in line with Welsh Government planning guidance. At the time of our work, the focus was on essential services with the aim of restoring normal and routine activities when it is safe and practicable to do so.
- 75 We found that the **Trust worked well to develop its operational plans and is continually identifying the resources needed to deliver its plans, but the CHC was not involved early enough in the development of plans. Effective monitoring arrangements are in place.**

Regular liaison with stakeholders during the pandemic helped the Trust quickly develop quarterly plans, although the Trust acknowledges that the CHC could have been involved earlier

- 76 In May 2020, the Welsh Government issued an operational planning framework to guide NHS bodies in developing quarterly plans. The Trust worked well with its Board in developing the quarter one and quarter two plans with both plans produced quickly and submitted to the Welsh Government by the required deadlines. The Trust ensured a process for approving plans given the submission deadline was before the Board was scheduled to meet. The process gave board members an opportunity to comment and challenge followed by the Chair's action and subsequent ratification by the Board.
- 77 The Trust engaged and collaborated with stakeholders throughout the pandemic, which helped shape the quarterly plans. The Trust worked with the Welsh Government, health boards and other partners, such as the Wales Cancer Network to develop its plans. Collaborating with partners has helped to identify factors that could reduce service capacity, to understand the impact on demand over the medium to longer term and to identify options for increasing service capacity. There is clear recognition by board members of the value of the partnership approach and the expertise brought by partners including the military, local authorities, the university sector, other health bodies and the voluntary sector. The Trust recognises that they need to ensure more timely discussions to allow the CHC to input into plans to change service delivery in response to COVID-19 and inform the next operational plan.
- 78 The Trust undertook a self-assessment against the Welsh Government's Essential Services Framework. The self-assessment identified that the Trust had been able to maintain its essential services during the pandemic, even where services were delivered differently. The Essential Services Framework has recently been updated and includes the Framework for the Reinstatement of Cancer Services in Wales during COVID-19. The Trust has included relevant actions in its quarter two operational plan to reinstate routine cancer services.

- 79 When developing its quarterly plans, the Trust undertook capacity and demand modelling taking into account the Welsh Government's and others' guidance on reinstating services. Capacity planning considers the impact of constraining factors (such as social distancing and infection prevention and control) and the potential for extending working hours/days and outsourcing options. Capacity planning considers the need to ensure staff, patient and donor safety and to minimise the risk of COVID-19 transmission.
- 80 At WBS, the focus for quarter two is on reinstating the small number of services that have been paused and increasing activity levels of services reduced as a result of the pandemic. The quarter two plan for WBS, by necessity, makes numerous assumptions around factors such as the COVID-19 clinic model, including social distancing and screening requirements, increase in demand for blood, activity returning to pre-COVID-19 levels, donor behaviour, workforce absence through shielding and deferral periods for donors recovering from COVID-19. WBS has highlighted the difficulties in quantifying demand for blood and is working with health board blood bank managers to keep informed about changing demand. WBS is planning on the basis that demand for blood will reduce initially by 20% but increase to 10% above normal levels over quarter two as health boards start to reinstate services. WBS forecasts indicate the service will be able to meet demand for blood during quarter two. WBS is also modelling expected blood collection levels and reviewing its clinic locations, as well as considering reopening community venues.
- 81 During quarter two, the focus for VCC is to reinstate its outreach service model, maximise service capacity at VCC and outreach locations, and develop additional service capacity with third-party providers. The Trust is taking a cautious approach but recognises there are opportunities to align new service models with its strategic objectives and transformational models of care. The impact of the pandemic on VCC's clinical service model was significant. Pre-COVID-19 over a quarter of VCC's services were provided in outreach locations or patient homes. However, all services were quickly centralised, with the aim of maintaining safe services for patients in a COVID-19 safe environment. In addition, significant patient treatment pathways were introduced, including transferring patients from radiotherapy pathways to systemic anti-cancer therapy (SACT) pathways, leading to an increase of 500% of SACT referrals in March 2020. Like WBS, VCC's demand planning is based on assumptions. VCC anticipates a gradual increase in demand for its services during quarter two, and a significant increase during quarters three and four.
- 82 The Trust is risk profiling patients to help plan and prioritise those most risk of harm (see **paragraph 51**).
- 83 Our review of the Trust's quarterly plans shows that they are operationally focussed and appropriately incorporate the required flexibility of services in the short term, in line with Welsh Government requirements. Both WBS and VCC have developed a set of key actions and risks to ensure they achieve the objectives outlined in their recovery plans.

Resources to deliver the plan

The Trust is continually identifying the resources needed to deliver its operational plans and restarting services and assessing the unknown implications of the pandemic

- 84 The Trust faced workforce resourcing challenges when initially responding to the pandemic due to several factors, including, for example, sickness absence, special leave relating to COVID-19. The Trust established a Workforce Hub to support additional recruitment, deployment of staff, manage workforce information and implement an effective infrastructure for staff wellbeing. A range of actions were implemented, including:
- increasing levels of internal staff recruitment, extending contracts for existing short-term/temporary staff and making temporary appointments to meet demand for blood services;
 - establishing an external recruitment supply chain to appoint staff via a fast track process to the Trust Bank staff pool;
 - engaging with the all-Wales COVID-19 Hub to deploy final-year nursing students to VCC;
 - completing an assessment of the organisation's business critical roles to enable the deployment of staff to support business critical areas;
 - developing a workforce dashboard (see **paragraph 54**); and
 - establishing a Workforce Cell to monitor key COVID-19 measures relating to staff safety and wellbeing.
- 85 Staff health and wellbeing have been a key priority for the Trust throughout the pandemic and it recognises that staff will be under increased pressure moving into the recovery phase. Our work found that the Trust has introduced a range of wellbeing initiatives, for example:
- introduced a workforce COVID-19 helpline for staff and managers;
 - adapted existing Trust health and wellbeing intranet pages to provide specific COVID-19 support and guidance to staff, including self-care, employee assistance programme, financial wellbeing and manager support;
 - providing wellbeing updates in daily communications with signposting to internal and external interventions and resources;
 - developed and implemented flexible working policies and practices around homeworking, shielding, annual leave extension, special leave, flexible working practices, temporary deployment, extension of childcare subsidy scheme and staff risk assessments;
 - allocating on-site break-out areas for staff to take time out;
 - the Trust's patient psychology team are providing support to staff and managers to support their teams;

- staff testing arrangements are in place and have been communicated to staff; and
- implementing risk assessment processes to identify staff who might be more vulnerable from the virus.

- 86 In recognition of the value of the staff break-out areas and the psychology services, the Trust is preparing business cases to enable it to continue to provide both on a continuing basis.
- 87 The recovery phase will see sustained work around staff health and wellbeing through the development of a Health and Wellbeing Plan, based upon the CARE model (create, assist, rapid, engagement). This will include launching a confidential online platform for staff to voice their concerns, provide suggestions / ideas for improvement as well enabling the Trust to collect useful wellbeing data.
- 88 The Trust's quarterly plans were both underpinned by financial plans indicating the cost of new service models with forecasts to March 2021. Financial plans have subsequently been adapted and updated to reflect more detailed demand and capacity planning. We set out detail about financial plans in **paragraphs 62 to 68**).
- 89 The Trust's plans highlight constraints on physical space at the VCC site. Limited physical space is a long-standing risk on the CRR but compounded by social distancing requirements and infection prevention and control guidelines related to COVID-19. The Trust is exploring options to maximise capacity at VCC and across outreach settings, for example, by extending working days/hours, reconfiguring the VCC estate, increasing the agency staff use. VCC is also exploring a range of options with health boards and third-party providers to maximise capacity and provide service resilience over the medium to long term. The options include the expansion of the Tenovus Mobile Unit to deliver SACT, expansion of the SACT homecare service and an increase in radiotherapy capacity in partnership with Swansea Bay University Health Board and the independent sector.
- 90 Should demand for acute oncology services increase above expected levels, VCC will implement its surge capacity plan. At the outset of the pandemic, the inpatient and assessment unit at VCC was expanded, increasing the number of available beds. To date, the expected demand has not materialised. However, we understand that there could be a staffing risk if capacity is fully utilised in the event of an increase in the COVID-19 infection rate. The arrangements are subject to ongoing review to enable VCC to develop service delivery options that it can apply to various scenarios.
- 91 For WBS, the easing of 'lockdown' has meant that some temporary venues utilised during the pandemic are no longer available as organisations reopen services. Furthermore, WBS's existing venues may remain unsuitable where they do not meet the requirements of the COVID-19 clinical operating model. Work is underway to identify suitable premises to use as blood donation clinics and share mobile blood collection facilities with other organisations.
- 92 Whilst not explicitly set out in the operational plans, the Trust is managing the risk of disruption, delays or inability to provide a full range of treatments and services if

the UK Government does not achieve a withdrawal agreement with the European Union by the end of 2020. The Trust's CRR identifies the risk to the availability of PPE, medicines and other supplies in the context of a no-deal withdrawal.

- 93 The Trust has embraced innovative digital solutions to maintain service delivery and comply with social distancing. Services are increasingly being provided virtually to reduce the need for patients to attend clinics. VCC has introduced remote consent for radiotherapy treatment, virtual assessment pathways for SACT patients and increased utilisation of virtual clinics (Attend Anywhere). The Trust's Digital Team has seen a significant increase in demand across its services during the initial response to the pandemic stretching its capacity. Subsequently it has identified a series of roles and functions that will be essential in maintaining service delivery and progressing key digital projects during this period.
- 94 The Trust is developing mechanisms to identify lessons learned from its response to the pandemic. Learning will inform planning for the remainder of the year and any potential increase in COVID-19 infection rates. The Trust plans to review IMTP priorities and actions as part of its quarter two Operational Plan, to consider whether the priorities and activities to deliver them are still relevant given the significant impact of COVID-19.

Monitoring delivery of the plan

The Trust has effective arrangements to monitor progress against its operational plans

- 95 During the early stages of the pandemic, the Trust's normal governance arrangements were amended, with the Board overseeing progress against the response and related plans. The Board has continued to receive its standard performance report, which clearly identifies where COVID-19 has affected performance. The July 2020 performance report included a significant improvement in the description of underlying reasons where performance is off track. The Trust is continuing work to refresh and improve its performance management framework.
- 96 In our previous structured assessment, we recommended that the Board should agree the information it requires to support its scrutiny of progress made to deliver all priorities (and supporting actions) set out in its IMTP. The IMTP demonstrates overall progress against delivery of the overarching strategic objectives and key deliverables was on target. The new IMTP tracker was implemented in 2020 and received by the Board in the January and March Board meetings. The IMTP tracker provides a good summary of objectives, deliverables in-year, progress made to date, overall status and key risks. The tracker could be improved by including the impact the actions had on delivering the Trust's strategic objectives.
- 97 The quarter two plan sets out the progress made against actions set out in the quarter one plan. A clear RAG rated approach, similar to the approach for the

IMTP, is used for tracking operational plan progress The RAG rating makes overall progress easily visible, but there is no information on the impact of the action taken.

- 98 Our Board observations found that numerous COVID-19 update papers were presented to Board during June and July 2020. Whilst update papers provide detail and assurance on many aspects of the Trust's response, the Board did not receive a summary drawing together progress made towards delivering the actions set out in the quarter one plan until the Board received the quarter two plan for approval. However, we acknowledge that the Trust had little opportunity to do so given the short window of time between submitting the quarter one plan and developing and submitting the quarter two plan.
- 99 The Trust has arrangements in place for the Board to monitor and scrutinise progress against the quarter two plan. In September 2020, the Board will receive a reporting of progress against the plan. Going forward, (assuming that the new committee structure will be approved) the Trust Quality & Safety, Performance & Assurance Committee will regularly scrutinise progress against quarterly plans. It is likely that the Welsh Government will require a single operational plan for the remainder of the year. Evaluating progress against the quarter 2 plan will help inform the development of the operational plan for the remainder of the year.



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Governance Arrangements during the Covid-19 Pandemic

Advisory Review Final Report

2020/21

Velindre University NHS Trust

Audit and Assurance Services

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Please note:

This advisory review report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee. Advisory review reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Velindre University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. INTRODUCTION

The NHS in Wales continues to face unprecedented pressure in planning and providing services to meet the needs of those who are affected by Covid-19 and other essential services.

At the time of this report, the number of cases of Covid-19 in Wales is in decline and there is an opportunity for NHS Wales organisations ('organisations') to take stock following the initial peak of cases experienced between March and May 2020.

This rapid advisory review was requested by the Executive Director of Finance to assess the adjusted financial and overall governance arrangements that were put in place to enable Velindre University NHS Trust (the 'Trust') to maintain appropriate governance whilst enabling its senior leadership team to respond to the rapidly developing emergency.

The key objective of the review is to provide independent, timely feedback to enable changes to be made to temporary governance arrangements if they are to be used in the future.

This rapid review was completed during late June and July and involved interviewing key members of the Trust and reviewing associated documentation supplied, where available. Whilst we have assessed this information against Welsh Government and other guidance, we have not undertaken detailed operational testing of the arrangements in place. We worked closely with Audit Wales to avoid unnecessary duplication with their work, sharing information where relevant and undertaking a number of interviews together.

Further detail regarding the scope of the review, the guidance used as the basis of the assessment and the review work undertaken are included in the appendices to this report.

We would like to thank Executive Directors and Independent Members for their time and contribution to this review.

2. EXECUTIVE SUMMARY

Main Observations

The Trust's temporary governance arrangements operated effectively during the peak. The Trust complied with the guidance and the principles issued by Welsh Government and there was a strong framework in place, with clinical input, to ensure maintenance of key governance principles and effective decision making.

Trust Board, Audit Committee, Quality & Safety Committee and Transforming Cancer Services Programme Scrutiny Committee meetings continued during the peak and the business of those meetings was appropriate.

'Virtual' meetings using Skype and latterly Microsoft Teams have developed, planned meetings have gone ahead and meeting etiquette has been developed and issued to all participants.

The Command Structure operated effectively and enabled the organisation to make decisions in an agile way. There is an opportunity now for management to look at the accessibility of evidence retained in support of decision making.

Financial governance was maintained and Covid-19 related expenditure is being separately identified and reviewed.

The Trust continues to assess the ongoing applicability of the temporary arrangements and is looking to revise the Trust's Committee structure.

Priority Considerations for the Future

We have not assigned priority ratings to considerations for the future, but we would highlight the following to be key areas of focus for the Trust to take into account as it reviews its processes:

- Ensuring the papers and minutes of meetings are made available as soon as possible after a committee meeting.
- Refreshing continuity plan(s) throughout the Trust to ensure lessons / experiences can be incorporated.
- Consider the likelihood of other non-Covid risks increasing during the pandemic, e.g. cyber-attacks.
- Ensuring that a separate Finance Business Continuity Plan is drawn up that not only covers loss of business systems but also plans for a reduction in staff numbers due to illness and other reasons.

- Continue engagement with commissioners to ensure contract payments for the remainder of the year are confirmed.
- Deepen engagement with the CHC in strategic change.

3. BACKGROUND AND CONTEXT

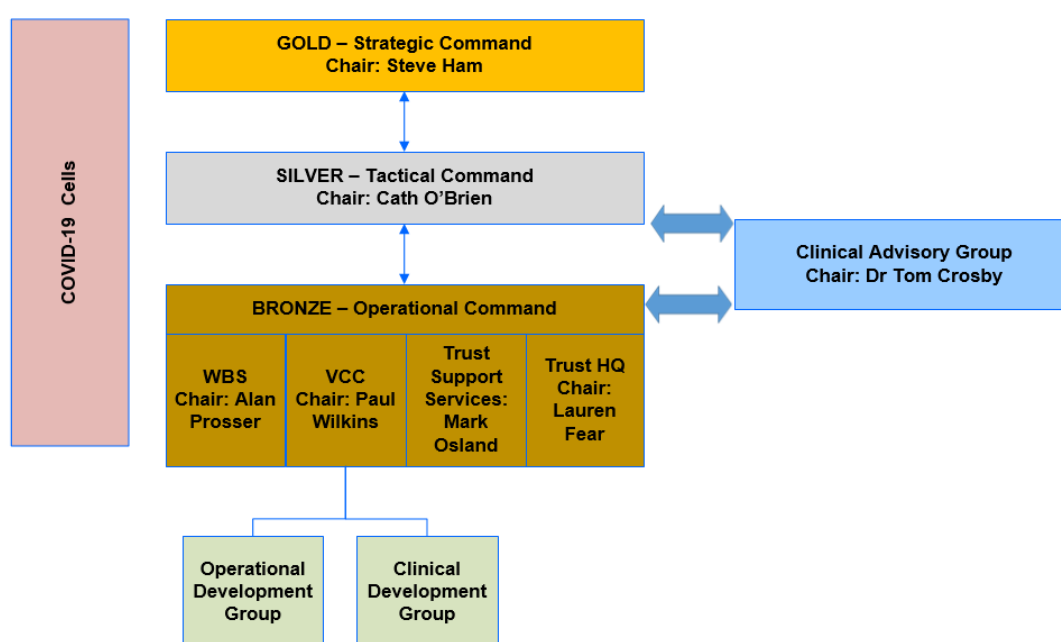
Overview of the Impact of the Pandemic on the Trust

As a result of the escalation of the pandemic the Trust had to review its service provision at Velindre Cancer Centre. A 'Clinical Governance and Operating Framework for Clinical / Patient Pathway Treatment Decision Making during Covid 19' was drawn up and approved by the Trust. All outreach services were 'drawn in' and re-provided within the Cancer Centre. A risk assessment was undertaken of every individual patients' treatment plan / pathway and changes agreed and documented in line with the Framework.

Within the Welsh Blood Service Division, social distancing measures were implemented within the processing services. An adaptation was made to the Bone Marrow programme to cryo-preserve all donations. A complete reconfiguration was undertaken of the blood donor programme reviewing location and cycles of donor venues and having active donor engagement. The Division, along with Welsh Government, has established the 'Convalescent Plasma Collection Programme' to contribute to the national trial taking place.

Command and Control Structure

The Trust established the following management and reporting structure outlined below to coordinate, prioritise and respond to the COVID-19 incident:



Within each level of the temporary command structure, it is expected that the Governance Principles (the 'Principles') set out by the Welsh Government and detailed within Appendix One, are embedded.

Adjusted Governance Arrangements

In addition to the Command and Control structure, the Trust implemented a range of temporary measures to facilitate new ways of working including:

- streamlining of the Board and committee structure including the suspension of committees of the Board, excepting the Audit and Quality & Safety and Transforming Cancer Services Programme Scrutiny Committees;
- the introduction of virtual meetings with the available telephone and video conferencing facilities and changes to the public's access to meetings and records; and
- an increase in use of the Chair's Action approval mechanism, to facilitate decision making between Board meetings.

The conclusions and considerations for the future in this report take into account the rapid onset of the pandemic at the beginning of its spread through Wales and the consequent impact on the Trust. Considered in this context, the Trust quickly established governance arrangements and continued to strengthen measures as more guidance became available.

4. DETAILED FINDINGS

This section sets out the detailed findings of the review, under the headings of Strategic Governance, Financial Governance and Other Areas of Governance.

Strategic Governance

1. Board and Committee Meetings
2. Scheme of Reservation and Delegation (SoRD) and Decision Making Arrangements
3. Risk Management

Financial Governance

4. Annual Accounts and Reporting
5. Financial Systems and Processes
6. Covid-19 Expenditure (Revenue and Capital)
7. Workforce
8. Budget and Savings

Other Governance Areas

9. Partnership Arrangements
10. Charitable Funds
11. Information Governance

Each section provides commentary on the adjusted governance arrangements put in place and considerations for the Trust to take into account as it plans for potential further Covid-19 peaks in the future.

Where we consider it appropriate we have suggested areas which should be given greater priority.

Strategic Governance

Board and Committee Meetings

What we found

Our review identified the following:

- The Trust implemented appropriate measures to ensure that Board and Committee meetings could continue to be held virtually in order to comply with social distancing and other Welsh Government guidance, with executive directors and independent members showing a great deal of flexibility. Furthermore, the Community Health Council (CHC) was represented at each Trust Board meeting. Members of the public were unable to observe Board meetings but at the 25th June Meeting it was agreed that the Board meeting scheduled for July 30th would be streamed live. Notices regarding the public's ability to attend the Trust's Board were published on the Trust's website on the Trust Board's meeting page.
- Outside of the formal Board and Committee structure, regular board briefings kept independent members informed and there was opportunity to challenge and support, with access to the key decision making logs.
- The Board, Audit Committee, Quality and Safety Committee (QPS) and Transforming Cancer Services Programme Scrutiny Committee continued to operate, with all other committees suspended. This was agreed at the April meetings of the Audit Committee and Trust Board. It was noted that the meeting frequency of the Quality & Safety Committee changed to monthly. We noted that the internet pages had not been updated to reflect the standing down of some of the Board Committees.
- For those committees that have been stood down, a paper was submitted to April Trust Board outlining the process for dealing with outstanding actions. The paper identified which continuing committee outstanding actions were remitted to and which actions had been placed on the Trust's Recovery Log.
- Virtual meetings have generally run smoothly with some teething issues using both Skype and Teams. We also note that guidance regarding 'good practice for virtual board and committee meetings' and 'tips for using Microsoft Teams' has been issued to all members. Chairing virtual meetings has been a challenge with etiquette developing over time.

- Agendas and papers of the Board and Committees were streamlined from April 2020 onwards. Due to the timing of the meetings so soon after the outbreak of the pandemic, March's Board meeting agenda had already been established but it was agreed at the meeting that only business critical activity be discussed and that all other business to be placed on a recovery log to be addressed in the Trust's recovery phase from Covid 19.
- An update on the recovery log was presented at each meeting of the Trust Board.
- Quoracy requirements and the standing orders remained unchanged, where committees still operated.
- Relevant risks were still escalated to the Board.
- Whilst Board papers have generally been published shortly following the meeting, there has been a delay with the publication of the papers for the April and July meetings of the Audit Committee.
- The Quality & Safety and Audit Committee papers ensured that key priorities (Covid and non-Covid) continue to be discussed.
- The temporary arrangements in place for the Board Committees were put in place initially for 3 months. At the Trust Board meeting that took place on the 25th June the Chair updated the Board to say that this arrangement would continue for the foreseeable future. The Interim Director of Corporate Governance is undertaking a review of the Committee structure with the view of proposing a new committee structure that will be submitted to the Trust Board for consideration and approval.

What could be done differently in the future?

We advise that priority should be given to considering the following:

- Ensuring the papers and minutes are made available as soon as possible after a committee meeting.

Furthermore, we suggest the following considerations as the organisation looks forward:

- Updating the Trust's internet pages to advise on status of Committees.

Scheme of Reservation and Delegation (SoRD) and Decision Making Arrangements

What we found

Our review identified the following:

- The Trust developed and implemented a Decision Making Framework that was approved at the Trust Board meeting held on 18th March 2020. The Framework clearly set out the decision making process and also the process for escalating and de-escalating issues and is a very good basis for setting out clearly how the organisation would respond to the pandemic. There was notable clinical involvement in the decision-making model and the clinical advisory group was a vital part of the process.
- To support the Decision Making Framework the Trust set up a Command and Control Structure to manage the Trust's response to the pandemic as follows:
 - Gold Command (Strategic) – Chair CEO
 - Silver Command (Tactical) – Chair COO
 - Bronze Command – (Operational) – 4 teams (WBS, VCC. Support Services & Corporate)
- In discussions we had regarding decisions made by the Trust we were advised these would be recorded on a decision log. We were provided with copies of the following decision logs:
 - National Guidance Decision Log;
 - Corporate Decision Log;
 - Gold Command Decisions;
 - Gold Command Action Log;
 - Silver Command Decision Log; and
 - Corporate Bronze Decision Log.
- The delegated financial limit for the Chief Executive was temporarily increased and approved at the private session of the Trust Board meeting held on 18th March.
- For the small sample of decisions that we reviewed we noted that all had supporting documentation.

- It is noted that the Gold and Silver Commands have been stepped down with responsibility transferred to the Trust's Executive Management Board and Operational Management Group. This was in accordance with National Guidance which advises stepping down of the command structure as the Trust moves from response to recovery phase.
- The organisation continues to reflect on experience during the pandemic and to utilise when planning for any future events.

What could be done differently in the future?

We suggest the following consideration as the organisation looks forward:

- The Trust should undergo a lessons learned review and where required put the necessary changes in place to ensure any learning identified internally is taken into account alongside the findings of this review.

Risk Management

What we found

Our review identified the following:

- The Board and the Quality & Safety Committee continued to receive the Corporate Risk Register throughout the pandemic.
- We were informed that Gold Command reviewed any Corporate Covid Risks and divisional related Covid risks were reviewed by Silver Command. From the Gold Command action log we were able to evidence risks being considered.
- The Trust uses the Datix system for recording all risks and a 'Covid' Flag was added to the system so that all Covid related risks could be easily identified.
- We were informed that there is no separate Finance Business Continuity Plan in place and whilst we have requested a copy of the Trust's Business Continuity Plan to assess the information included regarding Finance we have not been provided with a copy. We are therefore unable to assess the adequacy of Business Continuity arrangements in place for the Finance Department.
- However, business continuity was maintained with updates regarding the financial position regularly provided by the Executive Director of Finance to Gold command and to Trust Board. It is also noted that at the commencement of the pandemic the Finance Department drew up a critical function list with impact analysis and mitigating actions detailed.

What could be done differently in the future?

We advise that priority should be given to considering the following:

- Refreshing continuity plan(s) throughout the Trust to ensure lessons / experiences can be incorporated.
- Consider the likelihood of other non-Covid risks increasing during the pandemic, e.g. cyber-attacks.
- Ensuring that a separate Finance Business Continuity Plan is drawn up for use going forward that not only covers loss of business systems but also plans for a reduction in staff numbers due to illness and other reasons.

Furthermore, we suggest the following considerations as the organisation looks forward:

- Updating the Response Plan for any changes arising from this review and any other retrospective review being completed.
- Continuing to manage non-Covid risks and report to respective committees, to ensure that emerging risks are adequately reviewed / managed.
- Continually reviewing key objectives and priorities in light of new information.

Financial Governance

Annual Accounts and Reporting

What we found

Our review identified the following:

- The Trust worked to the revised accounts production timetable, with draft accounts submitted on 22nd May 2020. This is a notable success with the accounts being produced by the team working remotely.
- Audit Wales did not observe any significant issues in the audit of the draft accounts.
- The Annual Governance Statement was produced within the required timescales and complied with Welsh Government guidance.

What could be done differently in the future?

We suggest the following consideration as the organisation looks forward:

- The benefits and disadvantages of preparing the final accounts and completing the accompanying statutory audit remotely should be reviewed and retained for future financial years. Any efficiencies implemented to assist in the delivery should be retained / expanded upon.

Financial Systems and Processes

What we found

Our review identified the following:

- No changes were required of the current Financial Control procedures updated as a result of the pandemic. However, a variation to the Trust's Standing Orders was approved to reflect temporary changes introduced.
- We found evidence of redeployment planning in place for the workforce of the Trust.
- With regards to the management of stock we were advised that existing controls and procedures were still applicable, with no changes required. With regards to PPE, it was noted that additional storage capacity was purchased to house additional PPE stock. The Trust was also a member of the All Wales Group for PPE equipment that ensured all organisations had enough PPE stock for an agreed number of days.
- There were no Trust losses or write offs recorded during the pandemic.

What could be done differently in the future?

There are no improvements identified.

Covid-19 Expenditure (Revenue and Capital)

What we found

Our review identified the following:

- The Authorised Signatory List was updated to reflect the increased limit for the Chief Executive.
- Chair's Actions were utilised to ensure a swift authorisation of expenditure between Board meetings. These were subsequently reported to the next Trust Board for scrutiny and endorsement.
- Additional cost centres were set up to capture all Covid 19 expenditure. The expenditure recorded here was reviewed and challenged by the Finance Department and in some cases transferred back to the originating department.
- Our review of the monitoring returns submitted by the Trust to Welsh Government noted that there is now a schedule that details Covid 19 related expenditure incurred to date as well as future implications.
- Expenditure incurred via single tender and quotation actions are regularly reported to the Trust's Audit Committee under the Procurement Report agenda item. We note that at July's Audit Committee a schedule of all expenditure incurred outside of normal procurement guidance was presented for noting.
- The promotion of local counter fraud arrangements has continued throughout the pandemic.
- There is transparency of the capital expenditure that has been incurred to date. Procurement compliance reports have been presented to Boards and retrospective approval sought of procurement exercises that have been undertaken where it was clear at the outset that would be reacting to the decisions to be taken in accordance with regulation 32 (2)© of Public Contract Regulations.
- There was a great deal of scrutiny of PPE and other significant purchases made by NWSSP on behalf of Wales prior to approval by the Board including the NWSSP Financial Governance Group which included the Director of Finance and the Interim Vice Chair.

What could be done differently in the future?

There are no improvements identified

Workforce

What we found

Our review identified the following:

- The Trust developed a Workforce Operating Framework to Support Covid 19 Service Continuity with approval by Gold Command. Alongside this a Covid 19 Workforce Dashboard was developed that recorded information on recruitment, deployment, training & induction, staff absence, staff testing and risk assessments.
- A Fast Track Recruitment Process procedure was also developed and approved by Gold Command. All staff that were recruited under this process were appointed as bank staff; no permanent staff were employed.
- For those staff appointed the pre-employment process remained in place.
- We selected a sample to three staff appointments to ensure that the pre-employment checks had taken place. Out testing confirmed that the appropriate checks had taken place.
- It is noted that staff welfare featured prominently in the weekly updates issued by the Trust. The contents of the staff updates were agreed at Gold command.
- Overtime payments paid to senior managers (Band 8a and above) were limited to Workforce & Organisational Development staff operating the Trust staff help-line 7 days a week / 12 hours a day during acute phase of Covid 19.

What could be done differently in the future?

There are no improvements identified.

Budget and Savings

What we found

Our review identified the following:

- Budgets include pre-Covid and Covid expenditure, taking into account the impact of the pandemic.
- Amendments to budgets are integrated into the Monthly Monitoring Returns reported to the Welsh Government.
- Month end processes also incorporate the impact of Covid and monthly reporting processes have continued uninterrupted.
- The savings position is reported in monthly finance reports, which are subsequently reported to the Welsh Government but some schemes had to be paused as the Trust responded to the pandemic.

What could be done differently in the future?

There are no improvements identified.

Other Areas of Governance

Partnership Arrangements

What we found

Our review identified the following:

- The income that the Trust receives from other NHS organisations is via a block contract. The Covid 19 pandemic has had an adverse effect on the level of activity that the Trust has been able to provide. The Trust has reached an agreement with its commissioners that no financial penalties will be imposed for non-delivery services for quarters 1 and 2 for this year.
- With regards to quarters 3 and 4 it is currently uncertain whether payments will be based on activity levels which could represent a significant financial pressure for the Trust.
- Maggie's provided support services to staff during the pandemic which was greatly appreciated by the organisation.
- Engagement with the CHC continued throughout the pandemic, particularly as part of developing quarterly plans. Going forward it is expected that engagement in respect of strategic change will be greater.

What could be done differently in the future?

We advise that priority should be given to considering the following:

- Continue engagement with commissioners to ensure contract payments for the remainder of the year are confirmed.
- Deepen engagement with the CHC in strategic change.

Charitable Funds

What we found

Our review identified the following:

- We were informed that charitable donations are continuing to be processed in accordance with the charitable objectives of the Charity.
- No additional guidance was established, with processing / management of the Charity continuing to operate via the established team.
- The pandemic has had a significant adverse effect on the level of fundraising income forecast for 2020/21 due to the cancelation/postponement of a number of major fundraising events. An update on the financial position was presented at the Trust Board meeting of the 30th April 2020.
- A further report regarding the legal implications on sponsorship monies received for cancelled events was also presented at the Trust Board meeting of the 25th June 2020.
- An amendment was made to the existing procedure for registering gifts received by the Trust due to the unprecedented volume being donated by the public at the height of the pandemic. This amendment was approved at the Trust Board meeting held on 30th April 2020.

What could be done differently in the future?

We have no suggestions as the organisation looks forward.

Information Governance

What we found

Our review identified the following:

- The Senior Information Risk Owner (SIRO) is involved in the Strategic Group meetings and appropriate bronze level meetings.
- There is a strong link and involvement of the Information Governance Team around the procurement of IT and homeworking processes.
- A consistent approach across Wales has been established via the National Information Governance Managers' Group (IGMAG), which helps set processes and guidance for the use of technology at home.
- There has been a focus around Covid information governance risks, with a specific page on the Trust's website developed to provide guidance.
- Information governance advice and guidance has been provided as and when required throughout the pandemic.
- Face to face training has been suspended. E-learning has been promoted and the Trust is looking to progress training via Microsoft Teams.
- Privacy Impact Assessments (PIAs) and information sharing agreement protocols (ISPs) and privacy notices have been developed at a rapid pace for new measures implemented. For example, track and trace and video consultations.
- The Data Protection Impact Assessment (DPIA) process has been streamlined to remove redundant elements.
- Business Contingency arrangements have been enacted which allows the department to reprioritise their work and focus on service support needs.
- Operational processes for cyber security have not changed during the pandemic.
- Encryption and other security measures were maintained during the increased numbers of laptops (and other IT equipment) issued.
- Existing security arrangements have continued (for example, monitoring mail for viruses / malware etc.).

- The NHS liaised with the National Cyber Security Centre, with increased vulnerability assessments completed.
- NHS Wales Operational Security Service Management Board (OSSMB) meetings took place on a weekly basis, with the Associate Director of Informatics attending virtually.

What could be done differently in the future?

We advise that guidance is developed setting out:

- The need to maintain privacy in the household when using video conference / telephone call or other applicable work from other household members.
- Ensuring that laptops are locked when not in use / away from the desk. This is even more important in a public environment if agile working is to be promoted, for example, coffee shops. Consideration could be given to reducing the screen lock functionality within Windows.
- How physical copies of information are held and how they should be securely stored away from other household members / visitors.
- The risk that staff using their own devices at home are potentially more susceptible to malware / phishing attacks, as they may have insufficient security on their phones / home computers etc. This is likely to be more relevant with people able to access the OneDrive / Office 365 with just an internet connection from any device.

Appendix One – Guidance, Principles and Scope

Guidance and Principles

In its response (dated 26 March 2020) to a letter received on behalf of the Board Secretaries Group, Welsh Government agreed the Governance Principles that are designed to help focus consideration of governance matters.

The Principles are:

- public interest and patient safety;
- staff wellbeing and deployment;
- governance and risk management;
- delegation and escalation;
- departures from existing policies and processes;
- one Wales (acting in the best interest of the whole of Wales); and
- communication and transparency.

In particular, the Welsh Government reiterated the importance of continuing the role of both the Audit Committee and the Quality and Safety Committee during the Covid-19 outbreak, in supporting the Board with discharging its responsibilities.

Further detailed guidance was issued regarding financial governance in Covid-19 Financial Guidance to NHS Wales' Organisations and the Covid-19 Decision Making and Financial Governance Letter from Welsh Government dated 30th March 2020.

Scope of this Advisory Review

The advisory review assessed the adequacy and effectiveness of internal controls in operation during the Covid-19 outbreak, with particular regard to the Principles set out by the Welsh Government regarding maintaining financial governance.

This review focused on the following Principles:

- governance and risk management;
- delegation and escalation; and
- departures from existing policies and processes.

In particular, we undertook interviews and review of documentation:

- to ensure that appropriate key decisions are made through the revised management arrangements, with risk, impact and value for money adequately assessed;
- to confirm that the (revised) Scheme of Delegation and escalation requirements are adhered to;
- to ensure appropriate oversight and scrutiny remains by the Board over applicable matters – for example, the risk appetite level set;
- to ensure that departures from existing standards, frameworks, policies and procedures are appropriately documented and reviewed regularly, but still in accordance with the Principles; and
- to determine if the command structure established (i.e. Gold, Silver and Bronze) is appropriate – for example, achieving the Principles set out by the Welsh Government.

In our interviews with Board Members we discussed the remaining Principles and where appropriate commentary on those is included in the detail of this report.

The potential risks considered in this review are as follows:

- decisions are not completed in the best interest of the public;
- statutory requirements are not met;
- inappropriate expenditure and financial commitments;
- insufficient scrutiny of the risks associated with each key decision;
- the Welsh Government Principles are not adhered to; and
- inappropriate governance arrangements.

As this is an advisory review, the assignment is not allocated an assurance rating, but we have suggested some considerations for the future, should temporary governance arrangements be required in response to further peaks in the future.

Appendix Two – What we did

We undertook the following review activity:

- Interviewed the following:
 - Interim Director of Corporate Governance;
 - Executive Director of Finance;
 - Deputy Director of Finance;
 - Head of Financial Operations;
 - Financial Planning & Reporting Manager
 - Assistant Director Organisational Development;
 - Chair of the Trust;
 - Chair of the Audit Committee;
 - Chair of the Quality and Patient Safety Committee;
 - Director of Strategic Transformation, Planning Performance & Estates; and
 - Chief Executive.
- Reviewed notices, agendas and minutes of the Board, Audit Committee and Quality and Safety Committee from March 2020.
- Reviewed the public availability of the respective committee papers and in particular the hosting of them onto the Trust's webpage.
- Reviewed the risk register for Covid and non-Covid risks.
- Reviewed documentary evidence of assessment of committee business.
- Reviewed the SoRD and Standing Financial Instructions and any associated changes to the documents.
- Reviewed the Chair Actions relating to SoRD changes.
- Reviewed the Executive Management Board papers.
- Reviewed the papers / documentation / logs from Strategic Gold, Tactical Silver and Operational Bronze groups.
- Selected a sample of three key decisions from the Strategic Decision Log and reviewed the documentation of approval behind each of them.
- Reviewed the Authorised Signatory List.
- Reviewed the revised timetable for reporting of annual accounts.
- Reviewed the Monthly Monitoring Returns.

- Obtained and reviewed saving plans (including Covid and non-Covid savings).
- Reviewed the command structure for managing Covid arrangements.
- Obtained capital project information, including expenditure incurred.
- Discussed charitable funds arrangements and any changes to policies.
- Shared information and emerging findings with Audit Wales for consistency.

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CF14 4HH



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James Quance, Head of Internal Audit – james.quance@wales.nhs.uk
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TRUST BOARD

HEALTH AND SAFETY ANNUAL REPORT

DATE OF MEETING	26 TH November 2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Denise Hughes, Health and Safety Manager
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning, Performance & Estates
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
EXECUTIVE MANAGEMENT BOARD	2/11/2020	NOTED
QUALITY, SAFETY & PERFORMANCE	12/11/2020	NOTED

ACRONYMS	
	VCC – Velindre Cancer Centre WBS – Welsh Blood Service NWIS – NHS Wales Informatics Service

	<p>NWSSP – NHS Wales Shared Services Partnership</p> <p>Acronyms used in the body of graphs or tables are quotes taken directly from Datix</p>
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1. SITUATION/BACKGROUND

It is a recommendation from internal audit that, as part of the corporate assurance process, an annual report is received by the Trust Board on the management of Health and Safety within the organisation. This paper has been prepared to provide the Trust Board with the annual Health and Safety report from the Trust Estates Assurance Meeting for the financial year 2019/20.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Divisional and Hosted organisations regularly discuss Health and Safety and provide reports to the quarterly Trust Health and Safety management group and subsequently from 2020, to the Trust Estates Assurance Group, both of which have been chaired by the Assistant Director of Estates, Capital Planning and Environmental Development. Following the meetings, a highlight report is submitted to the Trust Executive Management Board and a ½ yearly highlight report is submitted to the Trust Quality, Safety and Performance Committee for information.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Safe Care
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.

1. RECOMMENDATION

Trust Board are requested to NOTE the annual report.

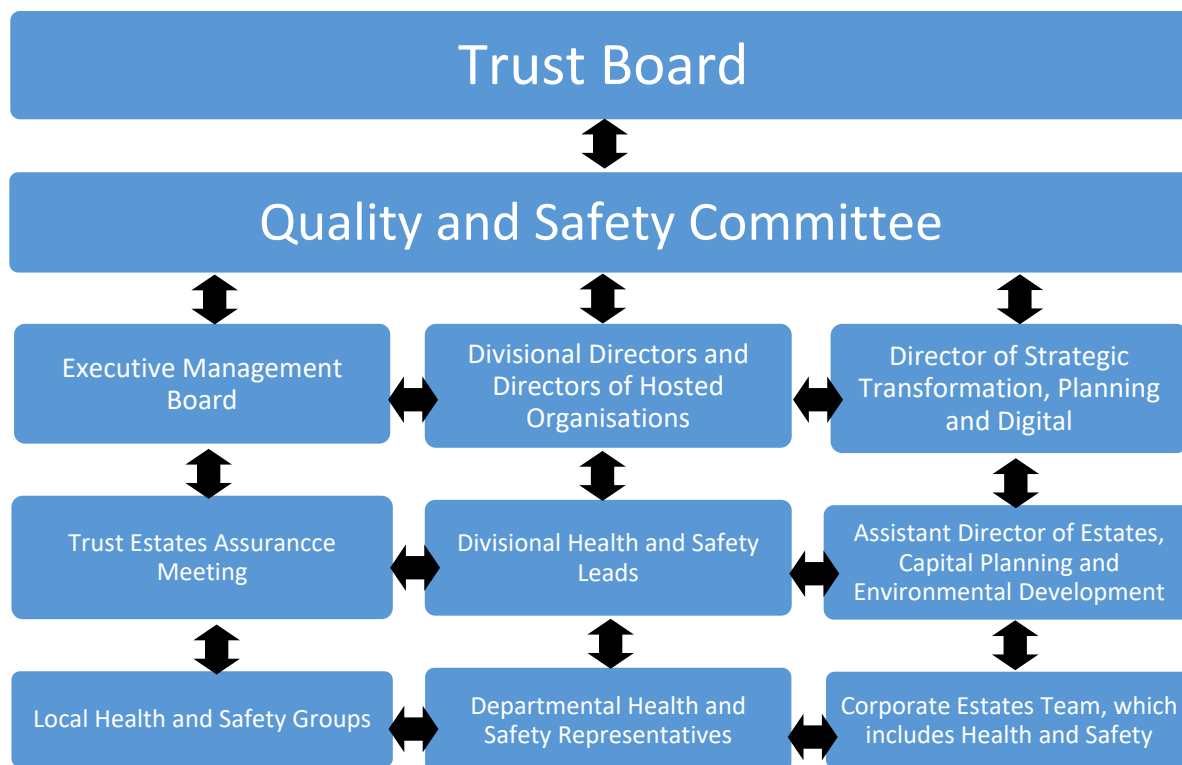
Annual Report

Health and Safety Management Group

April 2019 - March 2020

1. Corporate Management

During 2019, following a review of the Executive portfolios, the management of the corporate health and safety function was aligned to the Director of Strategic Transformation, Planning and Digital. The current reporting and communication arrangements for Health and Safety within the organisation can be represented as follows: -



2. Trust Estates Assurance Meeting – arrangements and responsibilities

The terms of reference for the Trust Health and Safety management group were reviewed in 2019 and, in 2020, Terms of Reference were created for the Trust Estates Assurance meeting. These required the monitoring of all areas of Health & Safety, Environmental, Fire Safety and Statutory Compliance, including (but not limited to): -

- Key Performance Indicators
- Policy Compliance
- Incidents
- New Legislation and Statutory Duties
- Estates Risk Register
- Claims Management and Infection Control

During 2019/20, the Trust Health and Safety Management Group / Trust Estates Assurance meeting met on the following dates: -

Member present or nominated deputy / date of meeting	H&S 24-07-19	H&S 04-11-19	TEA 12-03-20
Interim Director of Nursing & Service Improvement	-	N/A	N/A
Trust Quality & Safety Manager	-	N/A	N/A
Assistant Director of Estates, Environment and Capital Development	✓	✓ Ch	✓ Ch
Trust Health & Safety Manager	✓ Ch	✓	✓
Trust Fire and Compliance Manager	-	✓	✓
Legal Services & Governance Manager	-	✓	-
Head of Quality Assurance Welsh Blood Service	✓	✓	✓
Health & Safety Lead – Welsh Blood Service	✓	✓	✓
Health, Safety & Environment Officer Welsh Blood Service	✓	✓	✓
Health & Safety Lead – Velindre Cancer Centre	-	✓	✓
Health & Safety Lead – NWIS	✓	✓	✓
Health & Safety Lead – Health Technology Wales	✓	-	-
Health & Safety Lead – NWSSP	✓	✓	✓
Trust Infection Prevention Standards Control Lead	-	-	-
Environment Development & Compliance Officer	-	✓	✓
Representative from Workforce & OD for Health and Wellbeing	-	-	-
Representative from Workforce & OD for Training and Education	-	-	-
Occupational Health (Ad hoc)	-	-	-
Trade union safety representative/s Staff Side	-	-	-
Estates and Compliance Officer – NWIS	✓	-	✓
Representative from NWSSP Specialist Estates	N/A	N/A	✓
Environmental Development Officer	N/A	N/A	✓
Facilities Manager WBS	N/A	N/A	✓
Trust Estates Manager	N/A	N/A	✓

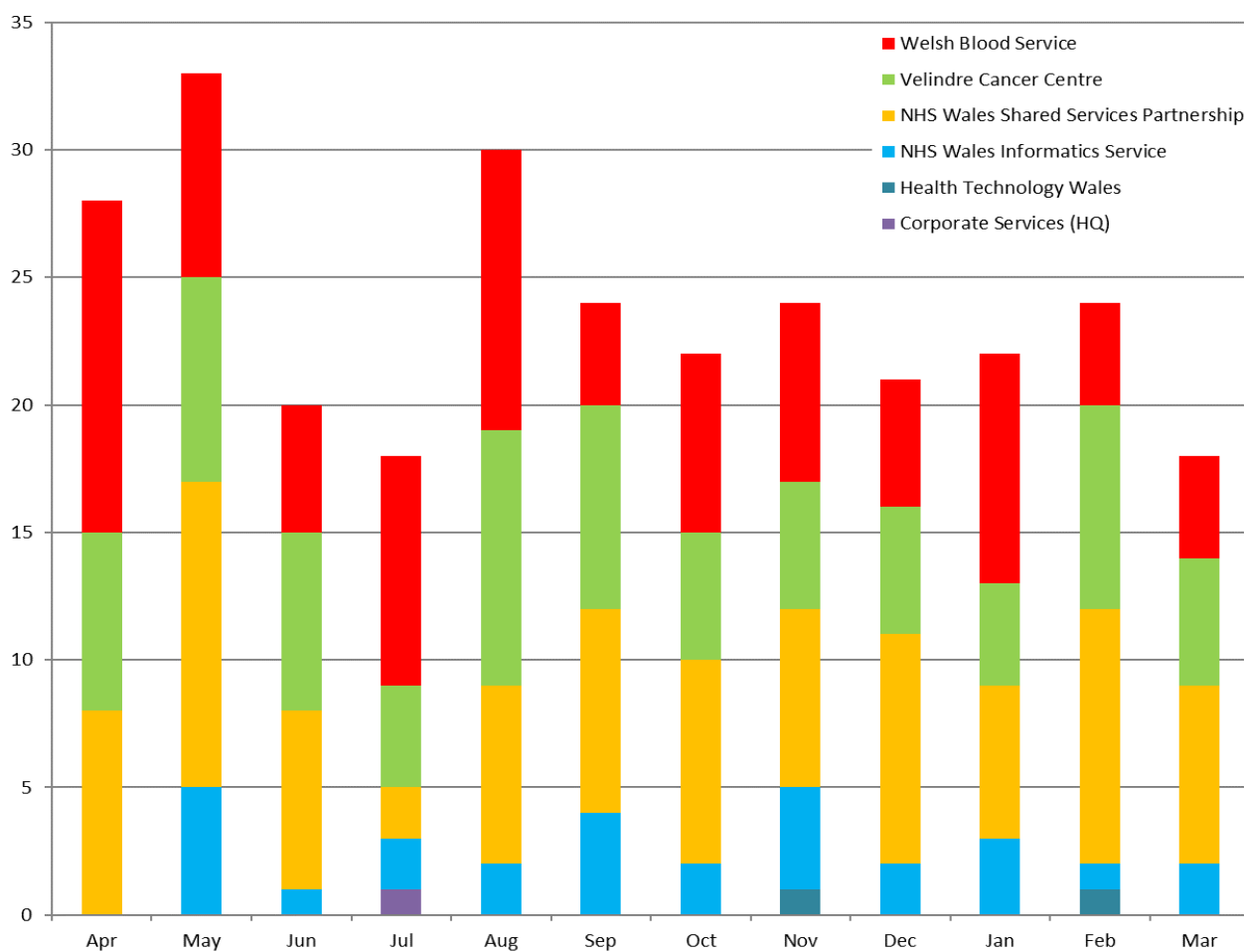
Representation at each meeting is shown in the table above and each meeting was deemed to be Quorate. Where a Health and Safety lead was unable to attend, apologies were noted and a nominated deputy (if available) attended in their place to represent the division / hosted organisation.

3. Incident Reporting and Statistics

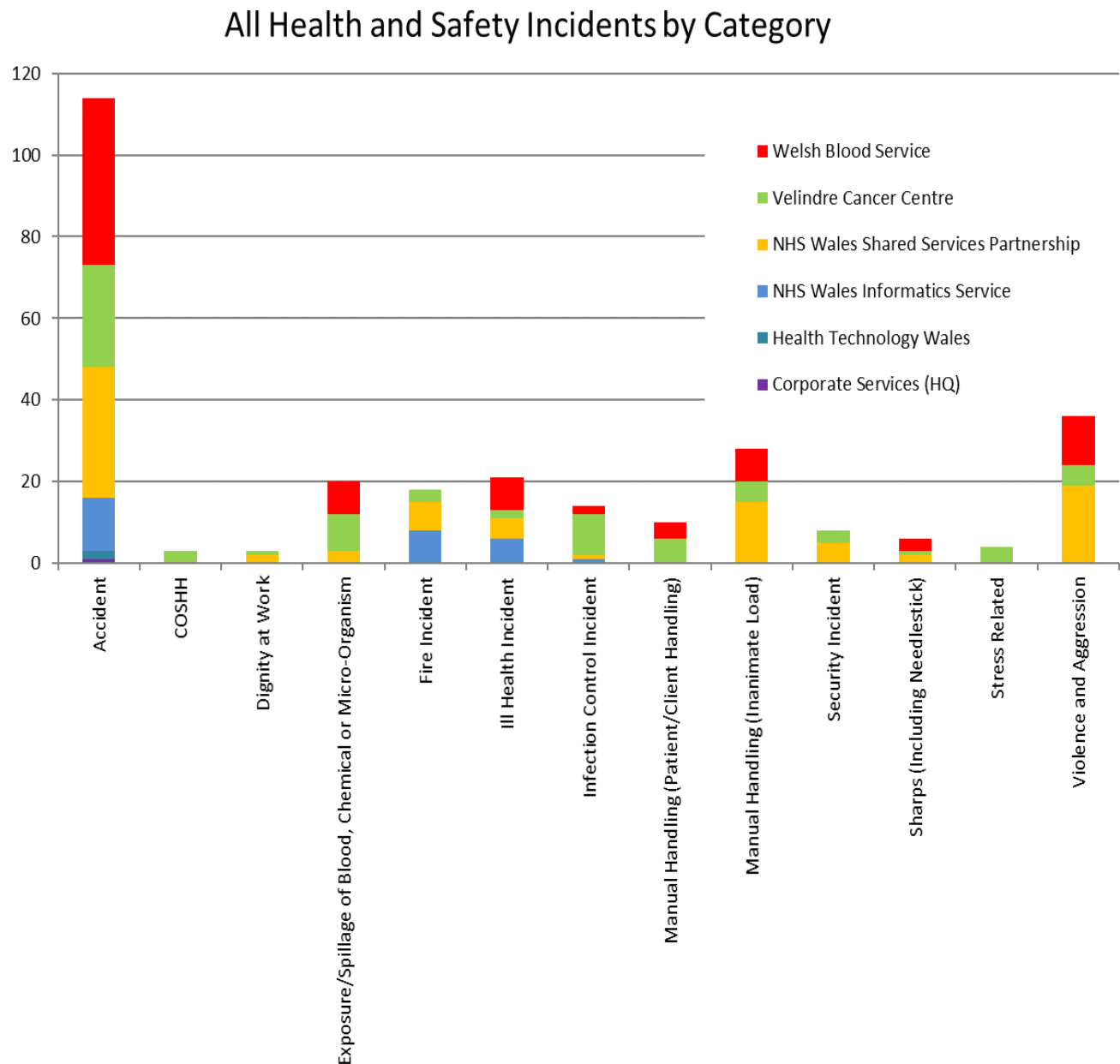
During the year 19/20, the Trust implemented a new Datix Risk Management System, which includes the incident reporting database. Due to the complexities of introducing a new system in a confined timescale, it was not possible for all divisions or hosted organisations to migrate to the new system at the same time.

On review of both systems during the reporting period, there were a total of 284 incidents categorized under the incident type of Health and Safety and they are broken down as follows: -

All Health and Safety Incidents by Division



The graph below indicates the number of incidents during the year 2019/20 by Incident Category:



4. Incident Review

There is a standard agenda item for the review of specific incident types, which are routinely reported at each meeting.

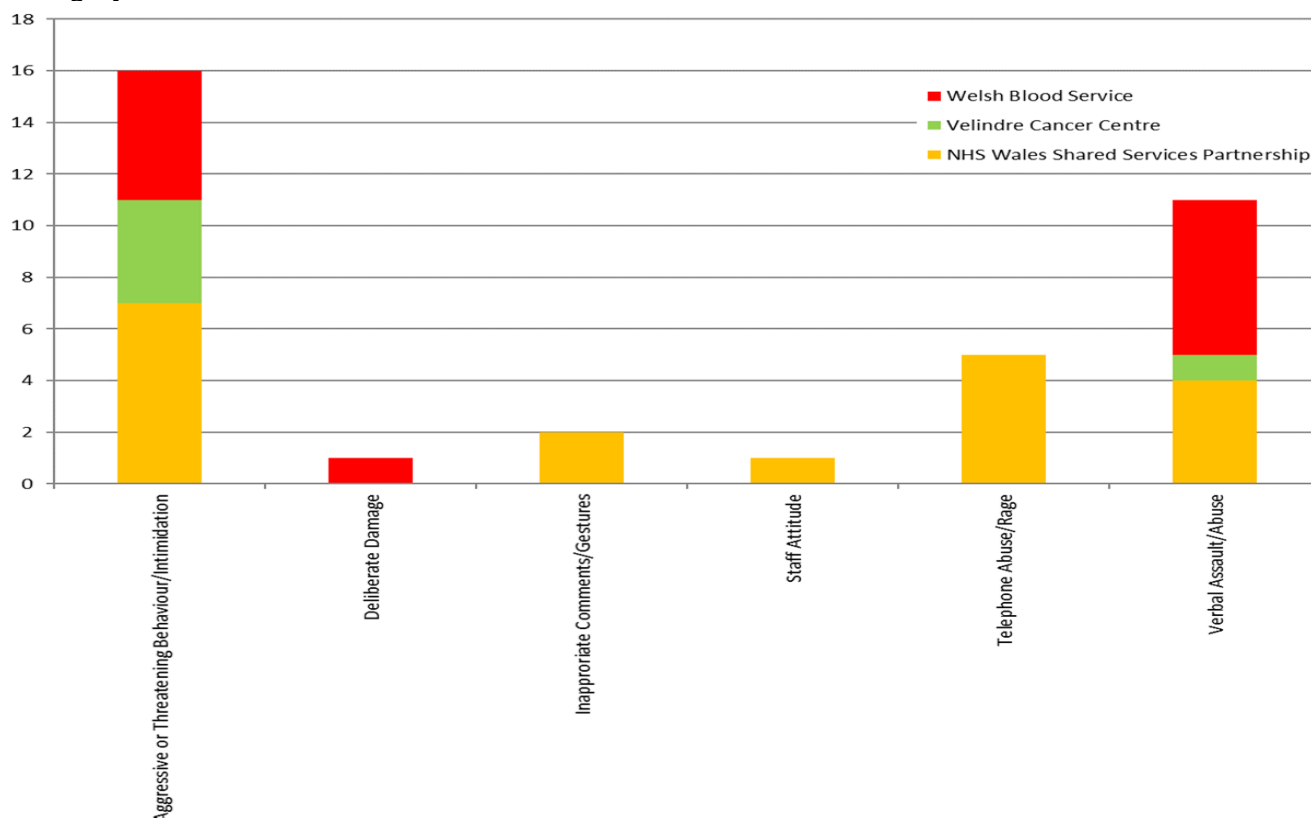
4.1. Trends

At each quarterly meeting, the incident category with the highest number of incidents is reviewed in more detail, to establish any trends. Throughout the year, once again, the “Accident” category has had the highest number of incidents reported. Further interrogation of those incidents has revealed that the highest number of incidents are again recorded under the sub category of “contact with and object”. This has been a consistent trend for a number of years. Each incident has been reviewed as part of the reporting process however, no obvious trends have been highlighted, with 45 incidents across all divisions and hosted organisations.

4.2. Incidents of Violence and Aggression

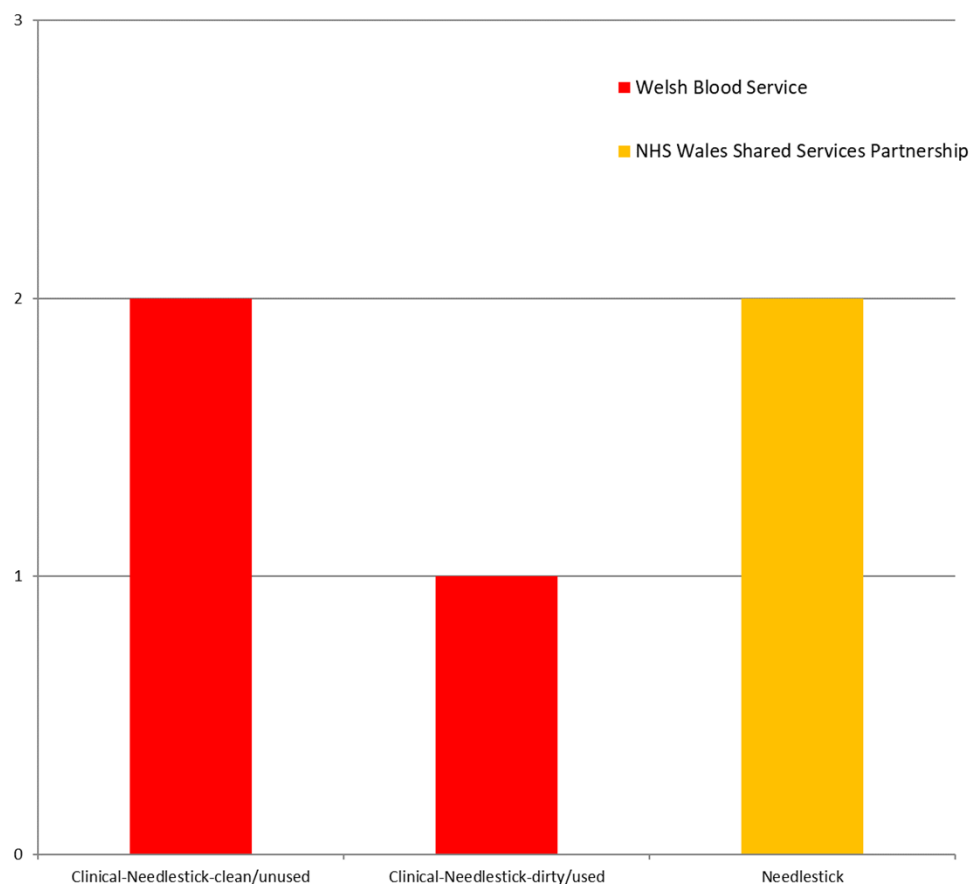
There have been 36 incidents of violence and aggression reported over the year, which is a decrease of 14 from the previous reporting period. The incidents have all been reviewed and discussed at each meeting.

Within the NHS in Wales, there remains a zero tolerance to any form of Violence or aggression. All incidents have been verbal or behavior related, with no actual physical assault on staff reported. The graph below demonstrates the violence and aggression incidents by sub category:



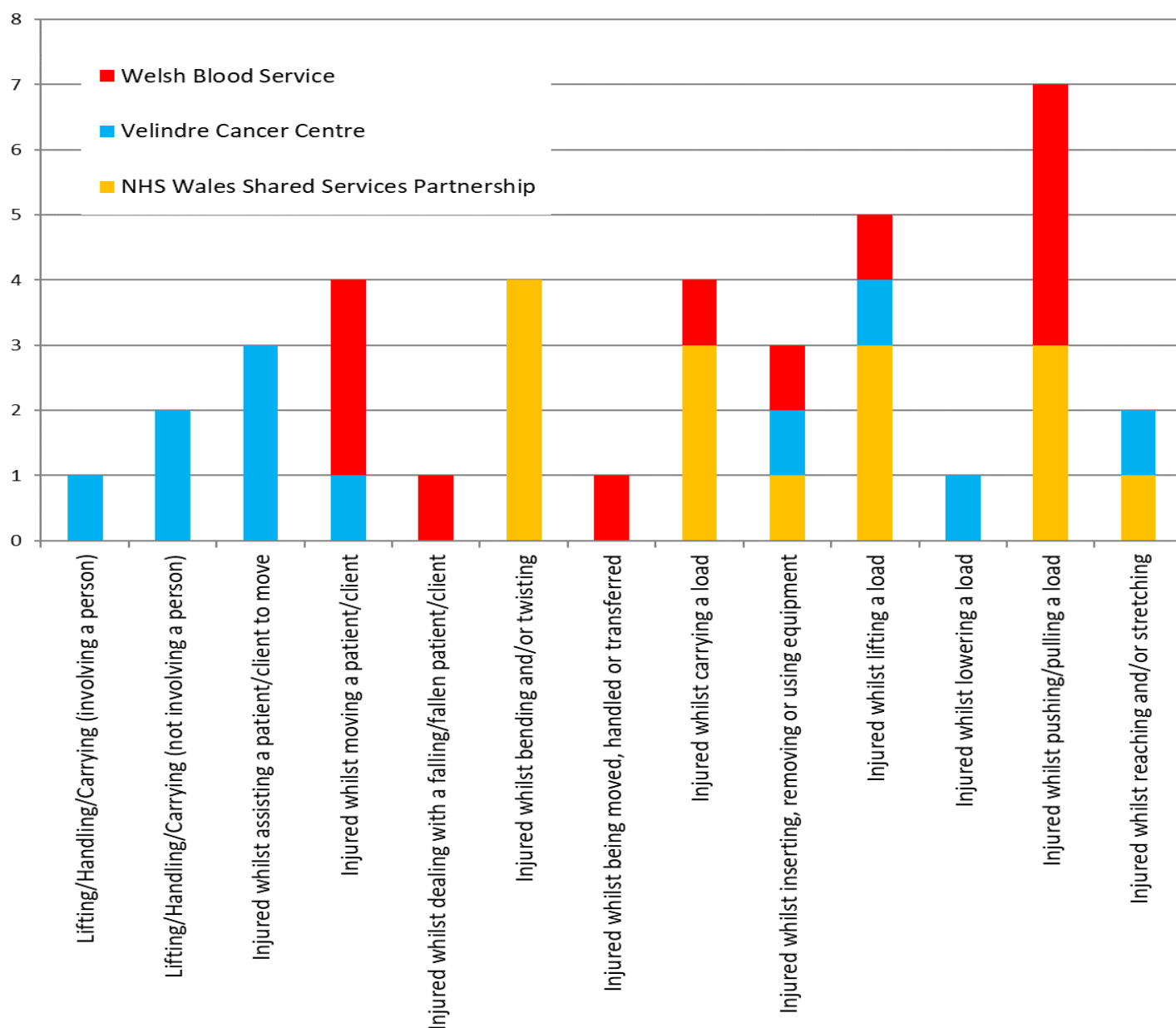
4.3 Sharps Incidents – including Needlestick

The following graph demonstrates the distribution of the 5 sharps incidents during the year. All 3 incidents with clinical needlestick injuries involved safety engineered devices as per the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The 2 NWSSP incidents involved the collection of sharps containers. 1 incident involved a used diabetic needle and 1 involved a small pin that had been used to take a blood spot.



4.4 Manual Handling Incidents

There have been 38 manual handling incidents, the majority of which have been recorded by the NHS Wales Shared Services Partnership.



30 of the incidents occurred whilst handling inanimate loads, of which, 7 incidents occurred whilst pushing or pulling a load. 8 incidents involved some form of client handling.

5. External Reporting

There is a requirement to report certain incidents to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), which include over 7 days' incapacitation and some specified injuries such as broken bones or fractures. It also relates to reporting dangerous occurrences and certain occupational health events. During the 12 months, there have been 10 incidents reported to the HSE: -

<u>Division</u>	<u>Category</u>	<u>Grade</u>	<u>Severity</u>	<u>Injury Type</u>	<u>Reported within HSE Timescale</u>
VCC	Manual Handling (Client Handling)	Low	Minor	Over 7 day Injury	No
NWSSP	Manual Handling (Inanimate Load)	Moderate	Minor	Over 7 day Injury	Yes
VCC	Manual Handling (Client Handling)	Low	Not Recorded	Over 7 Day Injury	Yes
VCC	Trip	Low	Minor	Over 7 Day Injury	Yes
NWSSP	Manual Handling (Inanimate Load)	Moderate	Not Recorded	Over 7 Day Injury	Yes
NWSSP	Manual Handling (Inanimate Load)	Low	Low	Over 7 Day Injury	No
NWIS	Trip	Moderate	Medium	Specified injury Fracture	Yes
VCC	Trip / Fall	Significant	Medium	Multiple Injuries	Yes
VCC	Fall	Moderate	Minor	Specified Injury Scalping	Yes
NWSSP	Manual Handling (Inanimate Load)	Low	Low (revised Datix Coding)	Over 7 Day Injury	Yes

Reporting to the HSE is undertaken locally within divisions and hosted organisations. All divisions and hosted organisations have been reminded that only work related injuries and work related ill health are reportable to the HSE and a central review process has been implemented to ensure a consistent approach of reporting to the HSE.

6. Health and Safety Policies

A key performance indicator for the Health and Safety Management Group has been the monitoring and update of policies and procedures. The following Health and Safety policies have been reviewed and approved by the trust Quality and Safety Committee during the current year to reflect the changes in the management structure for Health and Safety: -

- QS18 Health Safety and Welfare Policy
- QS09 Policy for the Management of Latex and Latex Allergy
- QS30 Lone Working Policy
- QS33 Policy for the Control of Substances Hazardous to Health (CoSHH)
- QS15 Management of Violence and Aggression Policy
- QS14 Safer Manual Handling Policy

7. Monitoring Health and Safety Performance

HSE Enforcement Notices

There have been no HSE Enforcement notices issued against the Trust during 2019/20

Hosted Organisations and Divisional Reporting

Local health and safety groups have been regularly held within each division and hosted organisations and highlight reports submitted to the Trust Health and Safety Management Group and subsequently to the Trust Estates Assurance Meeting for information and discussion. The Trust Health and Safety Manager has attended each of the local meetings across the organisation where possible.

Accountability and local reporting procedures also require that reports were regularly submitted to senior management within each division or hosted organisation.

Infection Control

The Trust Health and Safety Manager has, where possible, attended the scheduled Infection Prevention and Control Committee meetings, where regular reports on activity within the prevention and control of infection remit have been received and discussed as appropriate. Incidents, outbreaks and risks were discussed and an annual report on prevention and control of infection topics has been produced via the Prevention and Control of Infection Committee, for submission to the Trust Quality and Safety Committee. An annual report is produced for the Quality and Safety Committee. The most recent can be accessed [here](#)

Training

Compliance with both level 1 and level 2 training indicated within the Core Skills Training Framework, in the 3 areas of Health and Safety, is a standard Key Performance Indicator and a requirement within the divisional reports. Overall figures were received from the Education and Development Department and at the end of March, the compliance figures were as follows: -

<u>CSTF Subject:</u>	<u>WBS</u>	<u>VCC</u>	<u>Corporate</u>	<u>NWIS</u>	<u>NWSSP</u>
Health and Safety	89.8%	76.1%	79.8%	89%	96.71%
Manual Handling Level 1	95.2%	71.4%	66.1%	80%	94.22%
Manual Handling Level 2 (Client Handling)	94.8%	64.1%	N/A	N/A	N/A
Violence and Aggression Level 1	97.4%	84%	87.9%	84%	99.15
Violence and Aggression Level 2	89.8%	70%	56%	N/A	N/A

Fire Safety

The Fire Safety Management Group met throughout 2019, to consider matters relating to fire safety throughout the organisation, including training, audits and incidents. Like the Health and Safety Management Group, in 2020, Fire Safety transferred to the remit of the Trust Estates Assurance meeting. An annual oversight report on Estates Activity, including Fire Safety is produced for the Planning and Performance Committee and can be accessed [here](#).

Estates and Statutory Compliance

The Estates and Statutory Compliance Group considers health and safety issues as part of the standard agenda, such as the control and management of Asbestos and Legionella. An annual oversight report is also produced for the Quality and Safety Committee. The most recent can be accessed [here](#).

8. Key Performance Indicators

One of the core measures adopted by the Trust Estates Assurance meeting for Health and Safety, continued to include the recording of progress towards a set of Key performance indicators.

The key Performance indicators include reporting against the following areas and form an integral part of the reports received from each division and hosted organisation: -

Aspect	KPI
Health and Safety Policies	Relevant H&S policies in place and in date with supporting divisional H&S procedures
Health and Safety Competence	Relevant Health and Safety training is in place as required by the relevant policies and supporting TNA
H&S Audit	Annual audit on H&S management arrangements
H&S Inspections	Regular system of inspections are in place and undertaken
Incident Reporting and Investigation Policy	Monitoring accidents and incidents
Incident Reporting and Investigation Policy	Review of Risk Assessments
Incident Reporting and Investigation Policy	Reporting to External bodies (HSE)

9. Conclusion

The Annual Report includes information on the reporting framework, trends, incidents, training, and the audit of management processes, demonstrating the continued work of the Trust Health and Safety Management Group and the health and safety element of the Trust Estates Assurance Meeting over the year 2019/20.

With no HSE enforcement action in this reporting period, and the maintenance of the key performance indicators, this report has been able to demonstrate the continued commitment to the management and improvement of health and safety throughout the organisation. As health and safety continues to embed within the portfolio of the Director of Strategic Transformation, Planning and Digital, there is an opportunity to review the current structures and reporting mechanisms in order to ensure the continued progress towards an appropriate safety culture within the organisation.

TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST - QUARTER 3 / QUARTER 4 OPERATING PLAN

DATE OF MEETING	26/11/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Phil Hodson, Deputy Director of Planning and Performance
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	19 th October 2020	APPROVED
Trust Board (Chairs Urgent Action)	23 rd October 2020	APPROVED
Strategic Development Committee	5 th November 2020	APPROVED

ACRONYMS

VUNHST	Velindre University NHS Trust
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1. SITUATION/BACKGROUND

- 1.1 We have developed our Quarter 3 / Quarter 4 Operating Plan in line with the requirements of the *NHS Wales COVID-19 Operating Framework (2020 / 2021)*.
- 1.2 Our Operating Plan (*see Annex 1*) sets out our intentions from October 2020 to March 2021, in the context of the COVID-19 pandemic. It describes what services we will provide, where they will be provided from and how we will continue to ensure patient, donor and staff safety. It also outlines the arrangements we have in place for managing our capacity so that we can meet the expected increase in demand for services.
- 1.3 Our plan describes how we will maintain supplies of blood and blood products to the whole of NHS Wales; deliver essential tertiary cancer services to South East Wales and the enabling activities that will be undertaken by Corporate Departments. It builds upon the foundation established since March, with further developments of safe and stable clinical operating models over the coming months. The Operating plan also provides a strong foundation for planning and delivery of our services as we enter the winter period with the risk of a resurgence in COVID-19 infection rates, and the re-introduction of local lockdowns.
- 1.4 In summary the Plan outlines how we plan to meet the anticipated demand for services provided by VUNHST within the ongoing constraints of COVID-19 and the inherent unpredictable nature of the pandemic. We will do this by:
 - Continuing to develop and fully embed new ways of working to help manage the impact of any potential '2nd wave'
 - Maintaining 'Essential' services and working with partners
 - Keeping the Velindre Cancer Centre and Welsh Blood Service 'COVID-19 free'
 - Supporting our staff and communicating with our patients and donors
 - Managing all financial impacts and risks.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 There have been a number of developments since the publication of the Operating Framework Guidance for Quarter 1 and Quarter 2, and, although our understanding of the virus is improving, there still remains a high degree of uncertainty in terms of how it may impact services in the months ahead. The level of uncertainty has been further heightened

by the recent introduction of lockdown measures in Wales and the increased risk of a '2nd wave'.

- 2.2 From an NHS perspective this will continue to present a challenge to service planning as we interpret revised modelling projections and as new clinical evidence emerges.
- 2.3 Whilst we prepared for the initial COVID-19 peak in March 2020 it is now apparent that NHS Wales will have to adapt to co-existing with, and addressing the challenges of, COVID-19 for some time to come, and until a vaccine is developed.
- 2.4 The need to co-exist with COVID-19 whilst delivering safe and quality services to our patients and donors is a continued challenge. It requires a continued focus on new ways of working, making it essential that we retain the agile and flexible approach used to respond to the challenge of COVID-19 itself.
- 2.5 For our Quarter 3 / Quarter 4 Operating Plan we need to deliver and embed our capacity plans to meet anticipated increases in demand for our services. In addition, there is also an opportunity to align the '*new normal*' with our own strategic objectives and with our transformational models of care. We have also embraced the use of digital technology over the Quarter 1 and 2 periods and we are committed to expanding our ambitions in this area through Quarters 3 and 4 and over the medium-long term.

Our Priorities:

- **Delivering safe and compassionate clinical services** to the population we service which supports the efforts of the NHS and public service partners across Wales
- **Providing the equipment, staff and Personal Protective Equipment** required to deliver services safely
- **Providing testing for staff** to support them in safely managing their health and their ability to attend work
- **Supporting staff with their health and well-being** during work and their personal lives
- **Explaining what we are doing and the reason for doing it** to our patients, donors and partners and staff

Our Planning:

- 2.6 We initially planned our COVID-19 response in three phases
 1. Preparation

2. Peak and intermittent return of COVID-19
3. Recovery

- 2.7 March – July 2020 saw us go through the preparation and peak for the first wave of COVID-19 pandemic with August to September seeing us enter the recovery phase.
- 2.8 Our planning included the likely scenario of an intermittent return of COVID-19 during the recovery phase. This assumption has become reality and we are planning for the October 2020 – March 2021 period on the assumption that the virus will continue to be active in the communities we serve.
- 2.9 We are therefore re-activating our incident command arrangements, with weekly meetings in place. These will be escalated / stood down in accordance with the prevalence of virus in the community.

Planning Principles for Quarter 3 and Quarter 4:

- Our plan is aligned with our strategic goals and with our medium – long term plans and as outlined within our IMTP
- Our plan is based upon a clinically led risk management approach to service delivery in line with our clinical principles
- Our plan is in line with national policy and guidance e.g. social distancing
- Our plan has been developed in partnership with key stakeholders
- Our plan is based upon working regionally on solutions where appropriate
- Our plan is resilient and flexible so that we can adapt as the pandemic changes

Summary of the Service Plans:

- 2.10 The Welsh Blood Service Operating Plan is summarised below:
 - During Quarter 3 we will return to 'Business As Usual' for all essential services
 - A key focus for Quarter 3 is to review and revise clinic planning venues, location and capacity requirements
 - During Quarter 4 we will plan to support an increase in demand for blood products by hospitals as they undertake additional activity to address waiting list initiatives
 - We will continue to work with our internal teams, Health Boards and with the Welsh Government to develop a set of planning assumptions which support the delivery of our plan
 - Based upon our assumptions we will be able to collect enough blood to meet Health Board demand

Summary of the Velindre Cancer Centre Plan:

2.11 The Velindre Cancer Centre Operating Plan is summarised below:

- We aim to develop a resilient, quality driven, service model for VCC patients, which is able to respond to peaks and troughs in demand during COVID-19 throughout 2020-2021
- Our plan is flexible and includes options for the expansion of services in order to respond appropriately should a second wave occur and to accommodate patients repatriated from Health Boards and expected demand growth
- We will continue to deliver a full range of commissioned cancer services to our population
- Our focus is to maximise available service capacity within both existing cancer centre resources and to return outreach services to local Health Board communities
- We have worked with our internal teams, Health Boards and with the Welsh Government to develop a set of planning assumptions which support the delivery of our plans
- We have developed proposals for increasing capacity to respond to anticipated surge demand - these proposals will require additional investment

Monitoring the Delivery our Quarter 3 – Quarter 4 Operating Plan:

2.12 We have developed detailed action plans for the Welsh Blood Service, the Velindre Cancer Centre and for our Corporate Support functions. Each action within the plan has an accountable lead officer identified and a stated timescale for delivery. Delivery against the action plan is reported to the Executive Management Board on a monthly basis.

Risks to Delivery:

2.13 We have identified a number of risks to the successful deliver of our Operating Plan. In response, we have developed a comprehensive set of mitigating actions to reduce the likelihood of each risk being realised.

Financial Plan:

2.14 Our Operating Plan sets out our financial strategy and plan, including our assumptions around income and expenditure, anticipated cost pressures, planned investments and financial risks.

- 2.15** The expectation is that the Trust will achieve a balanced financial position in 2020-21. However, this is based on the assumption now that the new financial risk of committed COVID-19 expenditure (revenue & capital) will be funded by the Welsh Government.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
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 Trust Board is asked to **NOTE** the Quarter 3 – Quarter 4 Operating Plan.

TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING	26 th November 2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report	
PREPARED BY	Lauren Fear, Director of Corporate Governance	
PRESENTED BY	Professor Donna Mead, Chair	
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance	
REPORT PURPOSE	FOR NOTING	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
N/A		Choose an item.
ACRONYMS		

1. SITUATION/BACKGROUND

1.1 This reports provides information to the Board from the Chair.

1.2 Issues addressed in this report cover the following;

- Board Briefing on 22nd October 2020
- Annual General Meeting on 22nd October
- New Committees Update
- Reserved Forces & Cadets Association for Wales Annual Briefing
- Staff Survey
- A new collaboration between the Welsh Blood Service and Public Health Wales
- Improving cancer care in Wales and beyond
- VCC Charitable funds-ESOL Health awareness in BAME Project
- Remembrance Day 11th November 2020

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Board Briefings on the 22nd October 2020

2.1.1 The Chair would like to summarise matters discussed at the recent Board Briefing sessions.

2.1.2 During the session the Board:

- Received a presentation on the Quarter 3 and Quarter 4 planning assumptions. The approved plans are included in the Board papers (26th November 2020).
- The Board discussed the Communication and Engagement plan for the new Velindre Cancer Centre (nVCC).
- The board were informed of the process and draft timescales for the Nuffield independent Report.
- The Board discussed the impact of the COVID-19 Firebreak from the 23rd October to the 9th November with an action to update the Board on Business Continuity Planning at the November Board Briefing.

2.2. Annual General Meeting on 22nd October

2.2.1 The AGM took place on the 22nd October and livestreamed to the public. It was a packed agenda with the formal receipt of the Annual Report and Financial Duties for 2019-20. Plus a presentation from the Well Being and Future Generations Team, a celebration of

staff, NHS Pride 2019-20 and a virtual singing performance by Bronwen Lewis. The recording is available on the Trust website.

2.3 The Inaugural meetings of the new committees took place in November

2.3.1 The Chair confirmed that the inaugural meetings of the new committees took place in November as follows:-

- Strategic Development Committee on the 5th November 2020 – Chaired by Stephen Harries, Vice-Chair
- Quality, Safety and Performance Committee on the 12th November 2020 – Chaired by Janet Pickles, Independent Member

The Highlight Reports from the Committees are included in the Board papers (26th November 2020) and full Committee papers are available on the Velindre University NHS Trust Website.

2.4 Reserved Forces & Cadets Association for Wales

2.4.1 The Chair has attended Reserved Forces & Cadets Association for Wales Annual Briefing on the 19th November 2020 and will attend the Awards celebration on the afternoon of the 26th November 2020.

2.5 Staff Survey

2.5.1 The survey is currently live and closes on the 24th November which is when the survey provider will carry out the initial analysis. The findings will be shared with the Trust on 7th December and the plan is to analyse these results and the COVID19 lessons learned survey themes together and communicate the results and conclusions along with initial responses and actions.

2.6 A new collaboration between the Welsh Blood Service and Public Health Wales

2.6.1 The Chair is pleased to report that a new collaboration between the Welsh Blood Service and Public Health Wales will see one WBS' mobile blood collections vehicles being used as an abdominal aneurysm screening in Abergavenny next week at the same location that typically hosts blood donation sessions.

Due to current social distancing measures, mobile donation vehicles aren't being used for blood donation sessions as they aren't able to safely accommodate the number of staff and donors required. AAA screening requires far fewer people on board the vehicle at any time so WBS has arranged for the vehicles to be used for this important work while they are unavailable for normal service.

Communicating with donors used to seeing and using the mobile units for blood donation has been key so that they understand the change of use.

This is a fantastic example of how WBS regularly collaborates with NHS Health Boards across Wales. A similar example was the recent partnership with Cwm Taf Morgannwg University Health Board which gave WBS access to the Covid-19 field hospital in Bridgend to host blood donation sessions.

2.7 Improving cancer care in Wales and beyond

- 2.7.1 The Chair is pleased to inform the Board that Cardiff University, School of Healthcare Sciences and Velindre University NHS Trust have joined in partnership to grow research and develop a recognised centre of excellence in respect of Nursing, Allied Health Professional & Healthcare Scientist Research in cancer care & research in Wales and beyond.

The partnership includes recruiting a Professor in Nursing within Cardiff University for a three-year partnership to become Velindre Professor of Nursing and Interdisciplinary Cancer Care and a Velindre Research Fellow. This partnership has been possible due to the funding support of the Velindre Cancer Centre Charity and Cardiff University.

Professor Jane Hopkinson, from the School of Healthcare Sciences has recently been appointed to the role of Velindre Professor of Nursing and Interdisciplinary Cancer Care. Professor Hopkinson said, "I am delighted to take on the role. I will be working with nurses, allied health professionals, and clinical scientists at the Velindre Cancer Centre to grow research capacity and establish a recognised centre of excellence in nursing and allied health professional cancer research."

"The partnership between Velindre University NHS Trust and the School of Healthcare Sciences Cardiff University is important for cancer care research of benefit to patients and their families. Safe, high quality cancer care is associated with **research** activity. The new initiative will strengthen the synergistic relationship between the Velindre Cancer Centre and Cardiff University."

2.8.0 VCC Charitable funds-ESOL Health awareness in BAME Project

The Chair is pleased to announce that Cardiff and Vale College has won another award-for working with the BAME communities and increasing Health Awareness in these communities. Awarded by TES (Times Educational Supplement Magazine Award). All fully funded by the generosity of VCC charitable funds.

TES reporter: "The judges were blown away by the college's efforts to transform its community. They said: "Cardiff and Vale has adopted a real strategic approach around family learning and Esol. The reach of its initiatives is incredible, and there's a great sense of 'what next?' It's always travelling forward, constantly looking outside of its four walls."

2.9.0 Remembrance Day 11th November 2020

The Chair would like to thank Deputy Radiology Manager and Commanding Officer in the Royal Army, Simon Lawrence for leading the Remembrance service, Alexandria James for the Last Post, Lyndon Edwards for the flag donation and Robert Dunlop and John Bell for the wreath donation.

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	If more than one Healthcare Standard applies please list below: 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.

3 RECOMMENDATION

4.1 The Board is asked to **NOTE** the content of this update report from the Trust Chair.

TRUST BOARD

QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	26 th November 2020
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Janet Pickles, Independent Member
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, Allied Health Professionals, & Health Scientists
REPORT PURPOSE	FOR NOTING

ACRONYMS

PTR	Putting Things Right Regulations
PSOW	Public Service Ombudsman for Wales
SACT	Systemic Anti-Cancer Treatment
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Quality, Safety & Performance Committee at its inaugural meeting held on the 12th November 2020.
- 1.2 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. BACKGROUND

- 2.1 In September 2020, the Trust Board approved a new Board & Committee model resulting in the move from a top line nine committee model to a five committee model. Amongst a number of key changes, the revised model sees the establishment of a newly formed Quality, Safety and Performance Committee, encompassing the remit of the previous:
- Quality & Safety Committee
 - Workforce & Organisational Development Committee
 - Planning & Performance Committee
 - Digital & Information Governance Committee
- 2.2 The Quality, Safety & Performance Committee will meet on a bi-monthly basis, which commenced in November 2020.

3. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the inaugural meeting of the Quality, Safety & Performance Committee held on the 12th November 2020.

ALERT / ESCALATE	<ul style="list-style-type: none"> There were no items for alert/escalation to the Trust Board.
ADVISE	<ul style="list-style-type: none"> There were no items for advisement to the Trust Board.
ASSURE	<ul style="list-style-type: none"> Review & Agreement of Legacy Actions As part of the Trust, response to the COVID-19 pandemic a Trust

Governance Recovery Plan was established for those committees stood down during the COVID-19 pandemic. The Recovery Plan work had two aims:

- (1) To ensure we continue to manage and oversight those areas and actions that we needed to.
- (2) Structured way of cataloguing everything else that was placed in the "Recovery Log," so that this could all be tracked and then re-started in a planned and controlled way.

The Governance Recovery Plan status was reviewed in readiness for the inaugural meeting of the Quality, Safety and Performance Committee. The Committee was provided with details of five legacy actions from the previous:

- Quality & Safety Committee
- Workforce & Organisational Development Committee
- Planning & Performance Committee
- Digital & Information Governance Committee

The Committee received confirmation that two of the five legacy actions can now be formally closed; the 3 remaining open legacy actions will continue to be monitored and reviewed by the Committee through to completion ensuring that no actions from the previous Committee business is unaccounted for or not completed.

- **Quality, Safety & Performance Committee Terms of Reference and Work Programme**

The Quality, Safety & Performance Committee Terms of Reference were approved (attached in **Appendix 1**) along with the Committee work programme. It was agreed that the reporting of all hosted organisations needed to be strengthened and incorporated within the work programme.

- **Donor Story: Giving blood experience within the Welsh Blood Service**

The Committee was provided with the opportunity to view a video that had been developed by the Welsh Blood Service on donors' experience of giving blood during the pandemic. The Committee noted the excellent feedback highlighted by donors and received confirmation (following its recommendation) that the video has also been shared with Welsh Government, and that this has been well received by the ministerial team.



- **Triangulation**

The Committee received reports that brought information together across a number of key areas for the first time, which enabled both the integration of performance, with quality & safety reporting, together with finance, digital and workforce. The Committee noted that this enabled more effective discussion and holistic assessment of work being undertaken across the Trust for assurance.

One of the areas of triangulation identified by the Committee was the impact of the COVID-19 pandemic. The impact of the pandemic is adversely affecting key performance within Velindre Cancer Centre in relation to radiotherapy and SACT delivery, has resulted in an increase in numbers of complaints received, has resulted in a slight increase in staff sickness, and significant challenges in the delivery of mandatory and statutory training. However, the Committee also noted that the pandemic has driven forward a number of digital enhancements at pace as well as given the Welsh Blood Service an opportunity to be system leaders in respect of the establishment and delivery of Convalescent Plasma and the storage and distribution of COVID vaccinations.

The Committee commended the excellent work and commitment of staff to go the extra mile to ensure core service delivery could be maintained and highlighted the work undertaken by the support services, in particular the digital and informatics teams.

The Committee received assurance from the financial report that the additional resources that have had to be redirected by the Trust to support our response to COVID-19, will not adversely affect the year-end forecast, which remains on track to achieve a financial break-even position. This is based on the assumption that all COVID-19 related costs are to be fully funded by Welsh Government.

- **Trust Complaints (Concerns) Quarter 2 Report**

The Committee was provided with information on a number of draft key performance indicators currently in development to continue to improve reporting arrangements, together with the Trust compliance against the statutory reporting requirements for complaints, namely: Putting Things Right Regulations, Welsh Government NHS Delivery Framework, Ombudsmen investigations and Learning from Complaints.



The Committee received assurance that for the first time since Putting Things Right Regulations came into place, the Trust during this quarter achieved 100% compliance against the 30 working day response timescale against a Welsh Government target of 75% or greater. 80% of complaints graded as no harm / operational matters were resolved as an 'early resolution' i.e. within 48 hours. In addition, the Trust achieved 100% of complaints being acknowledged within two working days and had no complaints re-opened during the quarter. The Committee also noted the learning and service improvements that are taking place as a result of the slight increase in number of complaints/concerns received during quarter 2 which was anticipated as a result of the impact of the COVID-19 pandemic.

- **Flu vaccinations**

The Committee was informed that there has been an excellent response to the Staff influenza campaign to date with over 1,000 vaccinations being provided within the first week of the campaign launch on the 1st October 2020. As a result, the Trust now has extremely low numbers of flu vaccinations left. These are being prioritised for front line clinical staff currently. A small number have been acquired via a neighboring Health Board and further vaccinations are expected mid-November. However, it is anticipated that these will remain insufficient. Pharmacy colleagues are currently liaising with Public Health Wales Colleagues regarding the acquisition of the anticipated 200 vaccination short fall from the NHS Wales central supply. The Committee were advised that a full flu compliance breakdown report will be presented at its' next meeting in January 2021.

- **COVID-19 Vaccination Programme**

The Committee was provided with information on the Trust COVID-19 vaccination requirements. Definitive timelines are still awaited. At present it is anticipated that the earliest a staff vaccination programme will commence is January 2020. The Committee noted that the impact of COVID vaccine on our donors and our patients in the Velindre Cancer Centre would be a key piece of work going forward.

- **Divisional Quality, Safety & Performance Reports**

A new Divisional reporting template covering performance, quality and safety metrics and outcomes, patient / donor experience, staff experience, evidencing of lessons learnt, risk and forward looking

had been developed and were used for the first time by the two divisions. The Committee noted that the Divisional report generation using this template would mature over forthcoming meetings.

Velindre Cancer Centre

The Committee received a comprehensive report detailing progress made to address performance around Cancer Services' radiotherapy targets and Systemic Anti-Cancer Treatment (SACT), in particular, the impact of COVID-19 and the challenges this has presented in ensuring core service delivery is maintained. The Committee noted the challenges this has presented for both patients and staff, and acknowledged the ongoing commitment and ability of staff to adapt to the requirement to reconfigure service provision.

Welsh Blood Service

The Committee received assurance across key performance metrics and noted the ability of the service to continue to respond to the current challenges made to the collection model due to COVID and anticipated challenges moving forwards. The Committee commended the system leadership role adopted by the Welsh Blood Service during the pandemic and its role in the development of convalescent plasma and storage of COVID-19 vaccination programme.

- **Patient & Donor Experience 2019-20 Annual Report**

The Committee received the Patient & Donor Experience Annual Report. This is the inaugural Velindre University NHS Trust Patient and Donor Experience Annual Report. Previously the two divisions have reported patient and donor experience separately. The Committee noted that much work has been undertaken by both divisions in capturing patient and donor experience during the reporting period. Learning from patient and donor feedback has also been undertaken, and there are positive 'you' said, we did' examples contained within the report. A copy of the report is provided at **Appendix 2**.

- **Workforce Report**

The Committee received the Workforce report which highlighted the activities and areas of focus for Workforce and Organisational Development in relation to staff, availability, engagement and development. The Committee noted that there had been a slight increase in COVID related absences, however, these were very low

	<p>numbers. The Committee also noted that whilst the overall compliance for statutory and mandatory training has fallen slightly - level 1 81.5% down from 82.6%, level 2 - 60.7% down from 62.3% this needed to be viewed in the context of the COVID-19 within which staff are still operating.</p>
INFORM	<p>There were no items to inform the Trust Board on.</p>
APPENDICES	<p>Appendix 1- Quality, Safety & Performance Committee Terms of Reference</p> <p>Appendix 2 – Patient & Donor Experience 2019-20 Annual Report</p>

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Developed:	September 2020
Approved:	
Next Review Due:	

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".
- 1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee**. The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

- 2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:
- Evidence based and timely **advice** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the:
 - quality, safety and performance of healthcare;
 - all aspects of workforce;
 - digital delivery and information governance; and
 - **Assurance** to the Board in relation to the Trust's arrangements for safeguarding and improving the quality, safety and performance of patient and service user centred healthcare, workforce matters, digital delivery and information governance in accordance with its stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** to the Board:

- Consider the implications for quality, safety, performance, workforce, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board.
- Consider the implications for the Trust's quality, safety, performance, workforce, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators.
- Monitor progress against the Trust's Integrated Medium Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board.
- Advise the Board on aligning Service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.
- Monitor the Trust's sustainability activities and responsibilities.

- Monitor progress against cost improvement programmes.
 - Ensure that appropriate systems are in place to develop and approve all Business Cases above Chief Executive's authorised limits in line with agreed policy.
 - Provide initial scrutiny of all business cases above Chief Executive's authorised limits.
 - Monitor & review the Trust's Capital Programme Expenditure.
 - Ensure a system is in place and running effectively to prioritise schemes from the Trust Capital Programme.
 - Monitor and review performance against the Trust's Assurance Framework.
 - Ensure areas of significant service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation.
 - Monitor outcomes/outputs from service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery.
- 3.2 The Committee will, in respect of its assurance role, seek assurances that governance, including risk management arrangements, are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities.
- 3.3 To achieve this, the **Committee's programme of work** has been designed to ensure that, in relation to all aspects of quality, safety, performance, workforce, digital and information governance:
- Ensure that the Trust Policies, Procedures and Strategies consistent with internal and external requirements are implemented as appropriate.
 - The organisation, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor safety and safeguarding above all other considerations;
 - The care and services planned or provided across the breadth of the organisation's functions (including divisional/team and those provided by the independent or third sector) is consistently applied, based on sound evidence, clinically effective and meeting agreed standards;
 - The organisation, at all levels (divisional/team) has the right systems and processes in place to deliver, from a patient or donor perspective - efficient, effective, timely and safe services;
 - The workforce is appropriately selected, trained, supported and responsive to the needs of the Service, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;
 - There is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- The integrity of data and information is protected, ensuring valid, accurate, complete and timely data and information is available to support decision making across the organisation;
- There is an ethos of continual quality improvement and a safety culture that supports safe high quality care prevails;
- There is good team working, collaboration and partnership working to provide the best possible outcomes for citizens;
- Risks are actively identified and robustly managed at all levels of the organisation;
- Decisions are based upon valid, accurate, complete and timely data and information;
- The Standards for Health Services in Wales are used to monitor and improve standards across the whole organisation;
- All reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:
 - sources of internal assurance are reliable
 - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
 - lessons are learned from concerns, incidents, complaints and claims.
- There is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board.

3.4 The Committee will advise the Board about key indicators of quality, safety and performance, which will be reflected in the organisations performance framework, against which the Trust's performance will be regularly assessed and reported on through Annual Reports.

Authority

3.5 The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- Any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.
- Obtain legal or other providers of independent professional advice, and to secure the attendance of individuals external to the organisation who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Organisation at any meeting of the Committee.

3.6 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.7 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

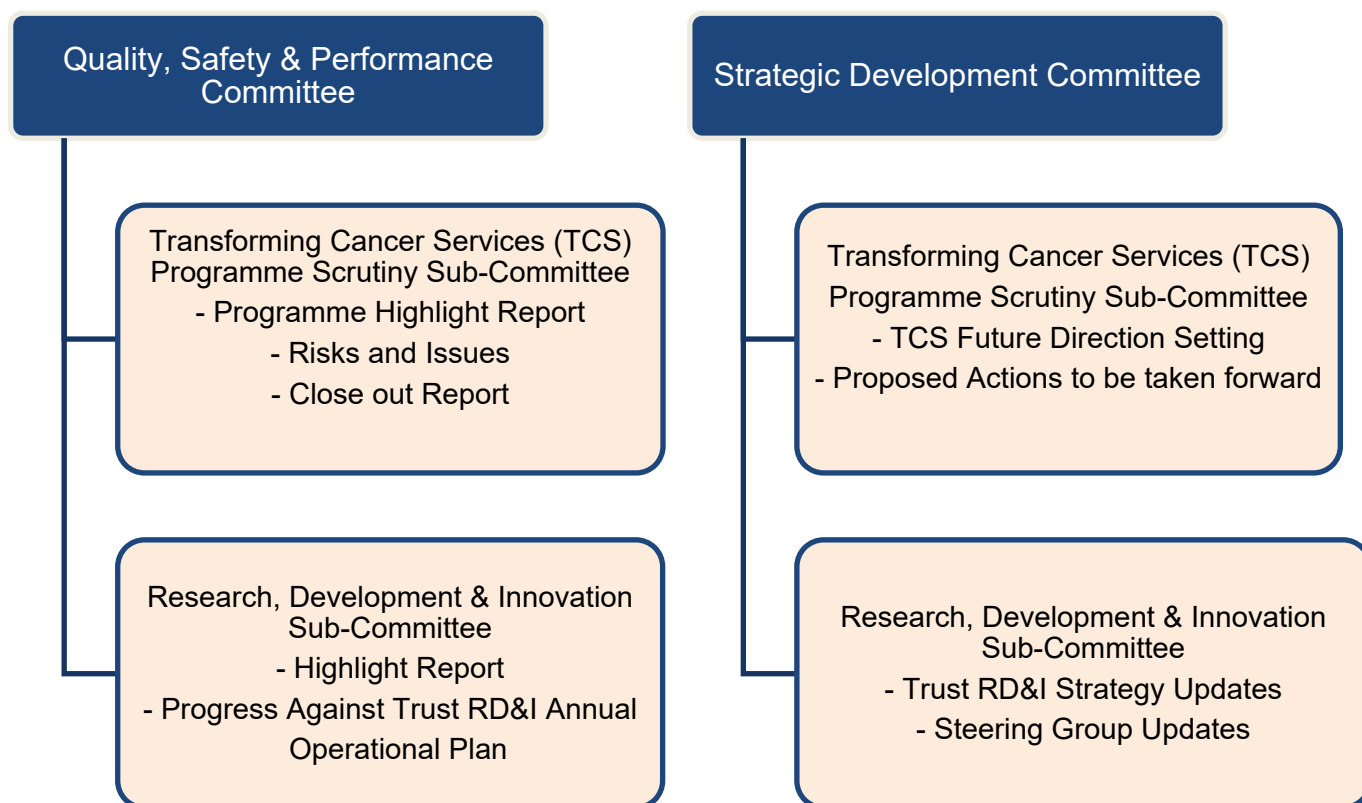
Sub Committees

3.8 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Appendix 1.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted by the Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

Members

3.9 A minimum of two (2) members, comprising:

Chair Independent member of the Board (Non-Executive Director)

One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

3.10 **Attendees:**

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director (*also Caldicott Guardian*)
- Chief Operating Officer
- Divisional Directors from WBS and VCC
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance
- Executive Director of Finance (*also Information Governance*)
- Executive Director of Organisational Development and Workforce
- Director of Strategic, Transformation, Estates, Planning & Digital
- Deputy Director of Nursing Quality & Patient Experience
- Associate Director of Digital (*also cyber/data outtages/performance*)
- Quality & Safety Manager
- Claims Manager
- Head of Corporate Governance

3.11 **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.

The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Wales Audit Office
- Trade Unions
- Community Health Council

Secretariat

3.12 Secretary - as determined by the Executive Director Nursing, Allied Health Professionals and Health Scientists

Member Appointments

- 3.13 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.
- 3.14 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

- 3.15 The Director of Corporate Governance, on behalf of the Committee Chair, shall:
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
 - Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce

4. COMMITTEE MEETINGS

Quorum

- 4.1 At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

- 4.2 Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Committee deems necessary.

Withdrawal of individuals in attendance

- 4.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 5.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.
- 5.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 5.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

- 5.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.
- 5.5 The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes verbal updates on activity, the submission of Committee Highlight Reports and other written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;
- Bring to the Board's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Trust.

6.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

7. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

7.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee.

8. REVIEW

8.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

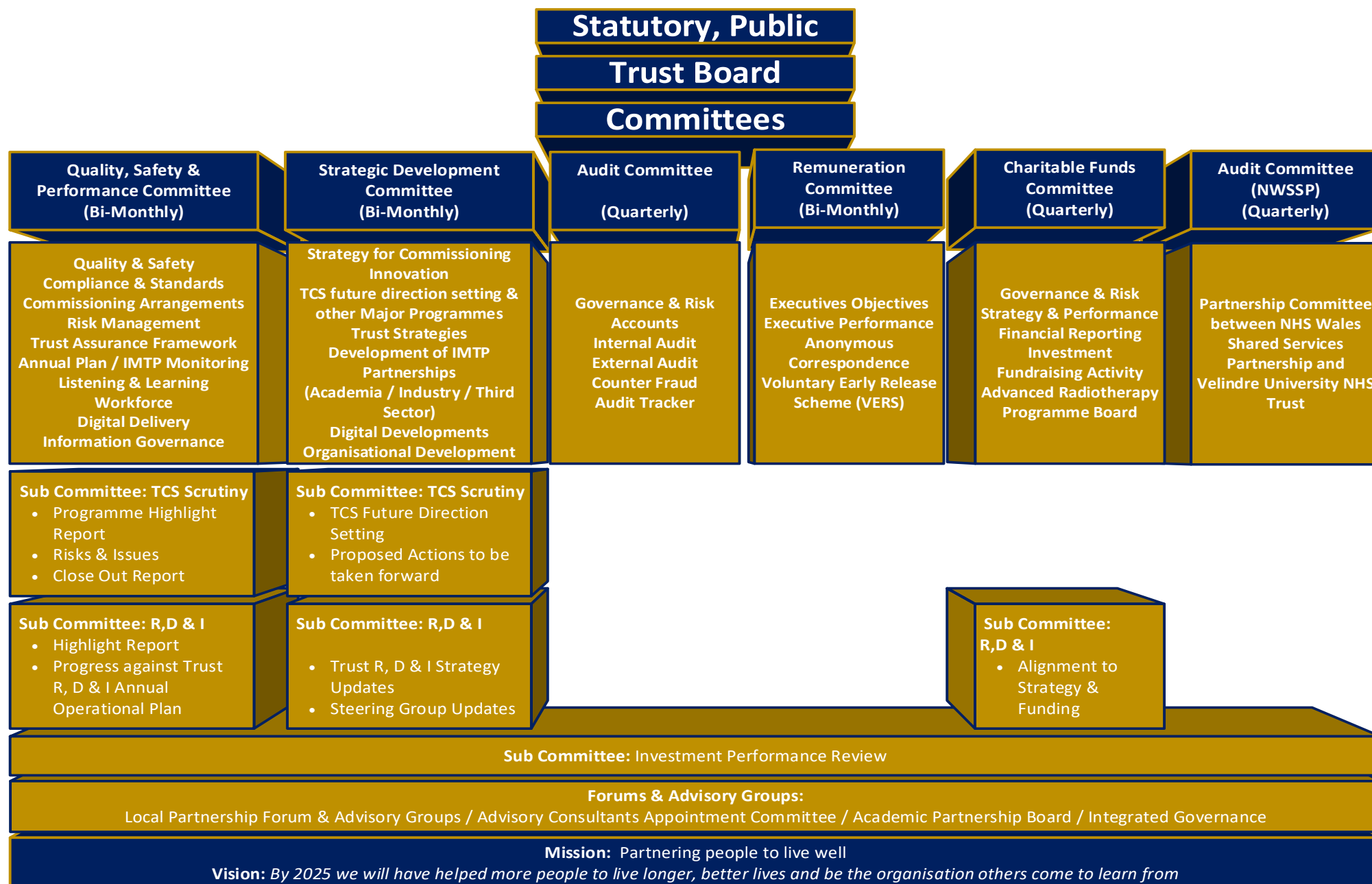
9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the

Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

- 9.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

APPENDIX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



TRUST BOARD

COVID UPDATE REPORT

DATE OF MEETING	26/11/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Anna-Marie Jones – Business Support Manager
PRESENTED BY	Cath O'Brien – Interim Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer Nicola Williams, Executive Director of Nursing, AHP & Health Scientists

REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
COVID Gold	Weekly Oct / Nov	

ACRONYMS	
PPE	Personal Protective Equipment
VCC	Velindre Cancer Centre

UPI	Upper Gastrointestinal Series
SACT	Systemic Anti-Cancer Therapy
IMTP	Integrated Medium Term Plan

1. SITUATION

This paper has been prepared to provide Trust Board with an overview of the Trusts plans and delivery in relation to COVID-19. This paper includes a summary of the impact that COVID-19 continues to have and the mitigations put in place to ensure our staff, patients and donors are safe and protected.

The Trust Board is asked to **NOTE** the contents of this paper.

2. BACKGROUND

The COVID-19 pandemic has presented various challenges to our staff, patients, donors and the delivery of our services. Our staff have had to adapt to working whilst wearing Personal Protective Equipment (PPE) and changing working practices whilst continuing to give the best care to our patients and donors. Equally our patients and donors are having to adapt to new guidance and advice when they come for treatment or to donate.

On 10th October 2020 the Trust re-established its COVID-19 command infrastructure that includes weekly Silver (Divisional) and Gold command meetings being held.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 *Clinical Principles*

From the outset of the COVID pandemic in March 2020, the Trust established a *Clinical Governance and Operating Framework for Clinical Patient Pathway /*

Treatment Decision Making During COVID 19 which enabled the decision making to balance patient risk from COVID-19 versus treatment options. In May 2020 this framework was adapted to encompass the “recovery” phase following the initial outbreak; recognising that this would last for 12-18 months. This included the plans for delivery of cancer services in Health Boards and the recommencement of screening services as well as reflecting the clinical learning gained and legacy effects from the 1st wave (attached in **Appendix 1**).

With the onset of the 2nd wave of the COVID-19 pandemic (Autumn 2020), the recovery guidelines are being reviewed in order to assess impact of the 2nd wave for patient treatments at Velindre Cancer Centre , patient COVID-19 testing and the underpinning plans for patient care at Velindre Cancer Centre. This review is currently being undertaken and will be formally ratified by the Cancer Centre Senior Management Team on the 7th December 2020. It is not anticipated that there will be any major changes to the principles, rather changes relating to operational implementation.

3.2 Trust Mission and Vision for the next six months

The Trusts Vision and mission for the next phase of the pandemic has been agreed through the Gold Incident Group and it was based on the Quarter 3 and 4 priorities detailed in the Quarterly planning Reports. It incorporates our approach and response to next phase of pandemic (attached in **Appendix 2**). In summary the focus will be on:

- Delivering safe and compassionate clinical cancer and blood services to the population we service, supporting the efforts of the NHS and public service partners across Wales;
- Providing the equipment, staff and Personal Protective Equipment required to deliver services safely;
- Providing testing for staff to support them in safely managing their health and their ability to attend work;
- Supporting staff with their health and well-being during work and their personal lives; and,
- Explaining what we are doing, and the reason for doing it, to our patients, donors and partners and staff

3.3 Velindre Cancer Centre

- 3.3.1. *COVID-Free Green Site:* The Trust is planning that Velindre Cancer Centre will operate as a COVID-free Green site. Clinical and operational discussions are underway to agree this and formal agreement is in progress.
- 3.3.2. *Staff facilities:* Due to social distancing and the importance of the maintaining the wellbeing of our staff, it was recognized that we needed to identify additional space for staff to access. Meeting room space has been converted into an area staff can access during breaks and have also increased capacity of the dining room by installing screens. In addition, a facility adjacent to the Cancer Centre site has been identified with a view to use for the wellbeing of our staff as well as extra office space and this will be ready in December 2020.
- 3.3.3. *COVID-19 Incidents / Outbreaks:* In the last two months there have been three incidents being managed within the Cancer Centre where more than one staff member have tested positive for COVID-19 within a short period of time. All have been managed tightly in line with Welsh Government incident / outbreak procedures and have not escalated or had any impact on service delivery. These have occurred in: Main Outpatients; Medical Records; and the Prince Charles Chemotherapy department.

3.4 Daily Welsh Government Incident and Outbreak Reporting

From the 9th November 2020 the Trust has been required to complete a daily Welsh Government Incident / Outbreak report. This system is aimed at the ability to provide prompt ministerial briefs and replaces the previous need to report such occurrences that would be reported on a Welsh Government no surprises notification. Serious Incident reporting is required to continue in tandem.

3.5 COVID-19 Vaccine Update

Significant work is underway to enable to Trust to effectively, efficiently and safely meet its responsibilities in relation to the provision of the COVID-19 vaccine to our staff once it is made available to us. Specific planning remains challenging as the specific availability dates and distribution quantities are currently unknown.

Responsibility for administration of the COVID-19 vaccine for the Trusts patients, donors and staff within hosted organisation lies with their respective Health Board.

At the time of writing the report the Pfizer mRNA vaccine which is known as 'Courageous' had not yet been approved by the MHRA. If it is, the vaccine will be stored and distributed by the Welsh Blood Service as it requires storage at -70 degrees.

The timescale for the commencement of the vaccination programme across the Trust could be any time between 2nd week in December 2020 and mid-January 2021. The vaccine will consist of two doses administered at exactly 21 days apart and there is a limited shelf life after the vials have been defrosted.

Detailed Trust and Divisional Plans are currently being drafted, aimed at the mass vaccination of patient and donor facing staff in the first instance, followed quickly by non-patient / donor facing staff. It is anticipated that the vaccine will be able to be administered by Registered clinical staff (awaiting Welsh Government sign off) and therefore the 'pool' of potential vaccinators is far greater than for influenza vaccines which are only, at present, able to be administered by Registered Nurses. Therefore there is the ability to have far greater departmental ownership and accountability.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined 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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

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 Trust Board is asked to **NOTE** the content of this paper.

Appendices



4.3.1 VCC

Appendix 1 - RECOVERY PHASE of



COVID Mission
PrioritiesCOB5.docx

Appendix 2 -



VELINDRE CANCER CENTRE CLINICAL FRAMEWORK FOR DEFINING THE CLINICAL MODEL AND TREATMENT DECISION MAKING DURING THE RECOVERY PHASE of COVID19

1. PURPOSE

This is a Velindre University NHS Trust document for use during the COVID19 Public Health emergency. As we move into the Recovery phase of COVID 19, it should be used as a replacement to the '**Clinical Governance and operating framework for Clinical patient pathway / treatment decision making during COVID 19**' reference paper 1.

The aim of the COVID-19 Recovery Phase – Clinical Framework for defining clinical / patient pathway / treatment decision making document is to provide a safe framework to support delivery of cancer treatments and services within Velindre Cancer Centre within the recovery phase of the pandemic.

It is recognised that the trajectory of pandemic recovery is uncertain and agility will be required and refinement as the weeks / months pass. There is also a potential for further 'peaks' which will require further review of the clinical delivery framework.

It is essential that any proposed changes to clinical pathways/treatment have a documented impact assessment. This will be undertaken using an Impact Assessment tool (attached in **Appendix 1**), to be signed off by the relevant site specific team (SST) Clinical Lead, and Clinical Director followed by 'Silver' or 'Gold' approval.

Patient outcomes will be actively monitored by Clinical Teams. Any adverse outcomes must be recorded on the DATIX system and a review of treatment / care pathway to be undertake. The risk register must be kept 'live'.

It is essential that the impact on the workforce / digital enablement /Regulatory Requirements /Communication strategy is considered for each action underlying each principle. Individual treatment decisions may need to be made on a case by case basis with input from patients and the respective multidisciplinary teams. Prioritisation will be overseen by the Nominated Trust Oncology Lead (Clinical Director).

2. DEFINITIONS

- **Recovery Phase:** The phase which occurs after the planning and peak phase of COVID-19 and is likely to have several stages within it including a further 'peak' at some point. We should assume that this period will last for at least 12 months and possibly as long as 18 months.



- **Essential Services:** “Services that are life-saving or life-impacting i.e. where harm would be significant and irreversible, without urgent or emergency intervention”.
- **Scheduled Care:** This is planned and routine care which includes Inpatient planned admissions, Outpatient attendances, Radiology visits, Radiotherapy related visits and Systemic Anti-Cancer Therapies(SACT)
- **Unscheduled care:** Unplanned health care such as emergency events which may be day case assessments, emergency radiology, in patient admission and Acute Oncology Services.

3. REFERENCES

This document has been developed in line with the following documents:

- Ref 1: Clinical Governance and operating framework for Clinical patient pathway / treatment decision making during COVID 19 [VUNHST 18th March 2020]
- Ref 2: Framework for Maintaining Essential Health Services during the COVID 19 Pandemic [WG]
- Ref 3: Draft NHS WALES COVID 19 Operating Framework-Quarter 1 [WG]
- Ref 4: Speciality guide for the management of non coronavirus patients requiring acute treatment for cancer [NHS NICE ref 001559]
- Ref 5: Ethical Framework NHS Covid19
- Ref 6: Operating framework for urgent and planned services in hospital settings during COVID-19 NHS

4. BACKGROUND

4.1 Risk to cancer patients of COVID 19

The cancer population considered at high risk of becoming seriously ill with coronavirus infection have already been defined (*Ref1*). Cancer patients continue to remain at high risk should they contract the disease, but the risk of community and hospital acquired transmission based on the R0 value is lower than previously. This is due to flattening of the peak incidence of Covid positivity in Wales as a direct consequence of the current national social isolation policy. It is anticipated that there will be an ongoing prevalence of COVID-19 for at least the next 12 -18 months. There is a great deal of uncertainty ahead and during this time it is anticipated that there will be fluctuations with further peaks and ‘surge capacity’ expected, although these are likely to be less intense. The impact of serology testing and the potential development of a vaccine, and the timescales for this, is yet to be determined.

4.2 Risk to cancer patients of not receiving optimal treatment



Cancer services in general have already been severely disrupted as a result of COVID-19. This is in part due to the impact on reduced screening and primary surgery but also the modification of therapy in order to minimise harm from treatments in the high risk cancer group. These pathway changes have resulted in a suppressed demand for non-surgical oncology services which will become manifest in the coming weeks.

In Velindre Cancer Centre, essential cancer care has been continued in line with the high level principles defined at the outset of this pandemic (*Ref1*). However, there have been a number of examples where patients themselves have asked to have treatments modified or stopped because of concerns around their individual vulnerability and the risk of being infected in a hospital environment. In addition, staff capacity has been reduced because of staff COVID-19 infection and this may be an ongoing risk.

4.3 National framework for Recovery phase in cancer

There is agreement across the system in Wales and the UK that we need to urgently restore our ability to deliver essential health services for our cancer population. Where possible we are also asked to consider recommencing more routine care. However we need to do this in a safe way, and with caution, through short planning cycles that maintain the flexibility and agility without putting our patients and staff at any increased risk. The Welsh Clinical Network is developing a framework for the recovery of Cancer Services in Wales during COVID-19 and these Velindre principles are aligned with this document, which is currently in draft form.

5. RECOVERY PHASE PRINCIPLES

5.1 Overarching principle of the Recovery phase

Velindre University NHS Trust has a responsibility to continue to deliver non-surgical cancer services and palliative care, defined as essential, and now to gradually recommence routine cancer services in a safe and controlled way, for the population we serve, whilst working in collaboration with the wider NHS.

5.2 Principles of care

The following principles which we have already outlined (*Ref 1*) still remain:

- Patient care and safety is paramount.
- Care will be provided based upon clinical need.
- Care will be delivered to maximise clinical outcomes at a patient and population level.
- Care will be provided at home or as close to home as possible.
- Staff safety and well-being will be paramount.

To achieve these principles, the following 3 key elements will be considered in parallel:



i) The **background risk** of community and hospital transmission which is influenced by societal movement control and determines the phase of COVID-19

.ii) The ability to become a **COVID-Protected service** apart from designated COVID+ve zones (recognising it will not be possible to control all aspects of this or do this in all areas)

iii) The use of **clinical prioritisation** to manage capacity and demand whilst minimising impacting on patient outcomes. The NHS NICE definitions of patient priority level previously referenced will continue to be used (*See Appendix1*) in considering the clinical prioritisation of patients, the following factors also need to be considered:

- The individual patient risk including factors such as age, performance status, sites of disease, comorbidities
- The COVID-19 status of the patient which may be negative, positive, suspected or recovered.
- The treatment modifications already made and any outcome measures seen.
- The impact of future therapy on the basis of already modified treatment pathways.

5.3 Key Strategic principles that determine the clinical model during the Recovery phase

Given our vulnerable patient group, we need to take additional measures in delivering care in a safe environment, i.e. one that is protected, as far as possible, against the risks of COVID. In addition to the current arrangements during COVID19, we need to create distinct treatment areas now 'designated as COVID protected' to resume non COVID activity. This will form the vast majority of space on site. This will now include Inpatients/Outpatients/Radiotherapy /SACT to allow services to resume.

- Risk mitigation strategies for designation of a safe site would include a systematic programme of managing access /rapid triage/screening/ testing and case contact tracing, where necessary of both staff and patients.
- Example of patient risk mitigation may include Pre-treatment self-isolation for a 14 day period, swab testing (48hrs pre-treatment) and CT chest imaging for specified high risk groups. In addition frontline staff may need to be tested weekly.
- The principle of social distancing needs to be applied for patients and staff alike. In clinical areas where the 2metre social distancing rule cannot be maintained, this is mitigated by appropriate use of PPE. This has an implication for home working/use of remote consultation and consent.
- Enhanced cleaning regime and IPC protocols including use of appropriate PPE which is risk assessed according to the patient and procedure is mandatory.
- In addition to the current arrangements during COVID19, we need to create distinct treatment areas now 'designated as safe' for non COVID activity. (Covid-Protected

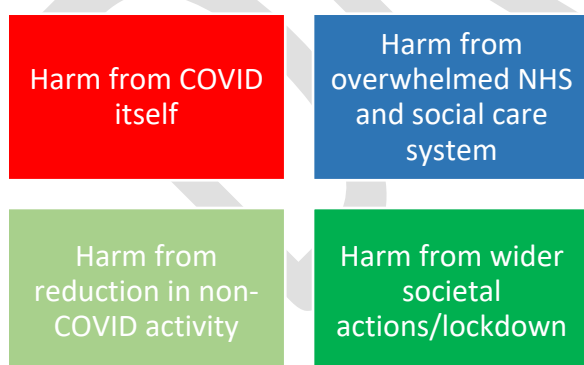


) This will form the vast majority of space on site. This will now include Inpatients / Outpatients/Radiotherapy / SACT to allow services to resume.

- We would also need to have the ability to continue to treat an expected but smaller number of COVID+ve patients should the need arise. Designated COVID+ve areas need to be defined within the service to include Inpatients, Outpatients, Radiotherapy and SACT. Moving these patients to alternative locations where possible should also be considered.
- Where possible and aligned to the principles of TCS, care should be delivered as close to home as possible and the footfall of patients at VCC, reduced to a minimum. In line with this Ambulatory care and Admission avoidance should be encouraged.
- We should continue to embrace new ways of working and efficient treatment monitoring protocols, supported by the appropriate digital infrastructure which allow remote consultations and consent to occur in cases where this is deemed acceptable by patients and relevant to their needs.
- We need to monitor patient and carer outcomes and feedback throughout the recovery phase.
- We should ensure that communication during this time involves clear, and coordinated messaging to patients, carers, external partners and our staff.

5.4 Principles aligned to National WG Operating Framework

We need to balance the risks for our cancer patients, in these 4 defined areas of harm, and make a clinical judgement on the benefits of treatment. The ethical framework will guide decision making which will be based on the principles that everyone matters equally but this does not mean that everyone is treated the same.



6. WAYS OF WORKING

The broad principles set out in *Ref 1* still remain in relation to ways of working. Key areas where there are differences with the recovery phase will be included under the existing headings of criteria and ways of working.



6.1 Minimise risk of Transmission

We should take all actions to reduce the risk of any transmission of COVID-19 across any service provided by Velindre.

- Work with other Cancer Centres, HBs and organisations in Wales to align with recovery protocols for COVID-19.
- Maintain the 2 metre distancing rule throughout the cancer centre apart from necessary clinical requirements.
- Patient screening pre-treatment, dependent on risk factors to include COVID history / Antigen testing/CT imaging/Self isolation protocols 7-14 days and contact tracing.
- Only bringing patients into the cancer centre if there is no alternative i.e. optimise virtual / telephone clinics.
- Defined hospital area for access, triage assessment and patient flows within outpatients, day case delivery, inpatients and radiotherapy.
- IPC principles i.e. Handwashing / Hand hygiene / minimise physical contact / staff education & training and clearly defined use of PPE for all areas including a risk assessed approach.
- Limiting / preventing visitors / patient support (OPDs) in line with current national guidelines / requirements; all exceptions to be agreed with Nurse or person in charge.
- Enhanced touch point chlorine cleaning and extended site cleaning hours.
- Minimise attendances and duration of stay for outpatient / day case attendances.
- Consider designated Radiotherapy facilities and timing of treatment e.g. end of day followed by appropriate zone cleaning.
- Reduce numbers and attendance at MDT using video links where at all possible. (as per WCN guidance).
- Staff screening: Enhanced staff testing and contact tracing programme in line with maintaining COVID-19 free zones.
- Support staff working from home, working remotely e.g. maintain new protocols for remote treatment consent, authorisation, approval.
- Review staff rotas to minimise risk of transmission, maximise skill mix, expertise, adequate capacity and oversight while ensuring adequate compensatory rest.
- Robust risk assessment of vulnerable staff including BAME individuals to determine appropriate areas of work.

6.2 Scheduled care

We should aim, wherever possible to recommence scheduled care in a stepwise approach maintaining the criteria 1 above. Where possible, and where it does not compromise treatment options we should reduce non urgent, face to face patient contact within Velindre Cancer Centre / Outreach settings. It is recognised that this approach will not suit all patient groups and needs to be considered on an individualised basis. This will mean:

- Continuing limited ongoing face to face routine follow up.



- Maximising use of remote monitoring where acceptable to patients and staff.
- Reviewing intervals between visits / surveillance / monitoring.
- Reviewing mode & choice of treatments.
- Strengthening Homecare.
- Reducing fractions of RT where appropriate to do so permanently e.g. Fast Forward for breast cancer.
- Consider safe recommencement of trial recruitment and follow-up in line with individual trial protocols.
- Revised pathways for palliative patients / end of life care dependent on options for this e.g. third sector provision/Use of Dragon heart hospital.

6.3 Understanding the Patient risk

In addition to the approach we have taken to minimise risk of therapy outlined in *Ref1*, in this recovery phase we should consider the ability to now reduce the likelihood of a patient harbouring the disease by intensive pre-treatment triage which may include 7-14 day isolation/screening with swab testing and use of CT imaging where relevant.

We should then **consider the** management of our **patients** in terms of:

- Their risk of contracting COVID-19(now significantly reduced in recovery phase)
- Their risk of immunosuppression during and following cancer treatment
- Balance this risk against likely benefits of treatment/care
- Identifying the known high risk groups: >70,PS 2+, pre-existing lung conditions,
- lung cancer, comorbidity e.g. diabetes, heart disease and hypertension
- Identifying the most immunosuppressive regimens
- Develop risk stratification by treatment type for SACT/RT or Combination SACT-Radiotherapy
- Review evidence for benefit of therapy for that individual or group of patients
- Review evidence for prioritization criteria: SACT and RT neoadjuvant / adjuvant/non-curative.
- Consider choosing less immunosuppressive treatments or regimens where this is still felt to be relevant, particularly to reduce the risk of respiratory toxicities such as pneumonitis e.g. RT versus CRT, RT versus surgery
- Rationalisation of therapy in palliative settings: extending intervals/single agents/Less complex RT
- We need to consider treatment protocols for patients who are asymptomatic and have tested COVID positive who will require repeated testing.

6.4 Unscheduled care

Non COVID Unscheduled care

Where appropriate, Velindre Cancer Centre would aim not to admit or manage patients with acute respiratory symptoms and suspected or confirmed COVID -19 (admission pathways to relevant HB). In line with being a COVID free zone as far as possible we would aim to test every patient on admission irrespective of symptoms. The existing

Admission Criteria would otherwise apply and we aim to continue to support LHBs in managing non-respiratory acute toxicities.

- Telephone triage to keep patients in the community in line with PHW advice.
- Effective Admission policy: avoid direct admission of suspected cases in line with HB agreement.
- Effective Discharge policy to reduce length of stay.
- Expedite a pathway for blood testing in the LHB.
- Delivery of treatment to home with adequate supplies.
- Use outpatient treatment regimens.

Suspected and or confirmed COVID-19 positive Unscheduled Care:

Velindre Cancer Centre will continue to have designated isolation / cohorting arrangements and clear patient triaging / pathways for activation:

- Consistent robust history taking and risk assessment (including of household members).
- Identifying the at risk groups: >70, PS 2+, pre-existing lung conditions, lung cancer, comorbidity e.g. diabetes, heart disease and hypertension.
- Identifying regimens that are most likely to immunosuppress individuals.
- Develop a pathway for isolation, assessment, testing and treatment that protects patients and staff.
- Develop pathways for escalation and resuscitation of COVID-positive cases.

6.5 Assessment Unit (AU)

Velindre should have a designated **assessment area** separated from any cohorting areas. The principles of reduced transmission (6.1) should be applied here. The assessment unit has been temporarily relocated and the feasibility of increasing from 4 to a maximum of 8 spaces is being explored. In addition, a two week pilot of 7 day working with 4 beds in use has been successfully undertaken. The recovery phase will consider the longer term implications and feasibility of this pilot. The AU will also include:

- Dedicated area with rapid turnaround AU for low risk patients (potential or unknown risk of COVID).
- Rapid on site testing for any suspected cases.
- Consider entry and exit routes for such an assessment unit.
- Clear signposting and communication for visitors.
- Primary care/community oncology services should be aligned to the function of the AU.

6.6 Flexible Inpatient capacity and Widening of admission criteria



GIG
CYMRU
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In order to support our health board partners with the management of cancer patients during the 'peak or future surge capacity period' we have considered a flexible approach to widening our admission criteria. We have also developed a plan to increase our bed capacity to up to 47 beds. The operationalisation of this will depend on social distancing requirements and demand across a number of areas including our own capacity to deliver priority SACT / Radiotherapy and would be considered in collaboration with our Health Board colleagues. The areas we could increase activity would include:

- Palliative Care
- End of life care
- Management of CUP(Carcinoma of Unknown Primary earlier in the pathway)
- Symptom control
- Suspected Cord Compression
- Non-COVID related treatment toxicities

6.7 Mutual Aid during the recovery phase

Staff will continue to participate in mutual aid programmes as required by NHS Wales following agreement with the health boards, VCC line managers and as compliant within job plans as appropriate.



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Prepared by: Trust Executive Medical Director & Executive Nursing Director and members of the VCC Clinical Team

Agreed by: EMB on 26/05/2020

Review Date:

DRAFT

Our mission during COVID-19 period: Phase 2: October 2020 – March 2021

Velindre University NHS Trust will do everything in its power to provide safe, effective and blood and transplant services and non-surgical tertiary cancer services to provide the greatest benefit for the whole population.

Our Priorities

- **Delivering safe and compassionate clinical services** to the population we service which supports the efforts of the NHS and public service partners across Wales.
- **Providing the equipment, staff and Personal Protective Equipment** required to deliver services safely.
- **Providing testing for appropriate staff** to support them in safely managing their health and their ability to attend work.
- **Supporting staff with their health and well-being** during work and their personal lives.
- **Explaining what we are doing and the reason for doing** it to our patients, donors and partners and staff.

Our Planning

We initially planned our COVID-19 response in 3 phases:

1. **Preparation**
2. **Peak and intermittent return of COVID-19**
3. **Recovery**

March – July 2020 saw us go through the preparation and peak for the first wave of COVID-19 pandemic with August to September seeing us enter the recovery phase.

Our planning included the likely scenario of intermittent return of COVID-19 during the recovery phase. This assumption has become reality and we are planning for the October 2020 – March 2021 period assuming that the virus will continue to be active in the communities we serve.

We are therefore re-activating our incident command arrangements, with weekly meetings in place. These will be escalated/stood down in accordance with the prevalence of virus in the community.

We have developed a plan for the October 2020 – March 2021 period to provide us with a direction of travel. The primary objective of the plan is to maintain cancer and blood and transplant services throughout this period. Our primary role has been agreed with NHS Wales partners.

How will we deliver our priorities?

The key actions are set out below.

Priority	Key actions
Delivering safe clinical services	<ul style="list-style-type: none"> Review of all non-core business activities that do not support our response to COVID 19 and redeploy all appropriate resources to support COVID-19 response. Cancer services: <ul style="list-style-type: none"> Review of clinical quality operating framework and clinical protocols to support clinicians/healthcare professionals in decision-making in collaboration with LHBs to ensure we are able to sustain cancer services an essential NHS service. Work with other LHB partners to identify opportunities to reduce any patient waits or provide treatment and in a different way/different setting including continuing to plan for additional capacity into 2021. Implementation of October 2020 – March 2021 COVID/Winter Plan (including securing of additional service capacity and office/workplace capacity). Monitoring of COVID-19 prevalence and impact of health services to determine step up in escalation levels of operation WBS: <ul style="list-style-type: none"> Ongoing review of blood demand with LHB colleagues and engaging with venues and donors to inform blood collection planning. Delivery of the convalescent plasma programme. Maintaining work of WBMDR and transplant services in line with Covid 19 operating model
Providing kit, equipment and medicines	<ul style="list-style-type: none"> Constant update of guidance on PPE and equipment to support staff safety Continue to work with NHS Wales and NHS Wales Shared Services to secure the required PPE to deliver safe care. Working with pharmacy colleagues, procurement, and industry to secure the supply chain for medicines and other products. Work with NHS Wales to understand/mitigate any risks to key supplies resulting from Brexit.
Staff and patient testing	<ul style="list-style-type: none"> Work with NHS Wales and Local Authorities to maximize the effectiveness of the Track Test Protect system to ensure timely and effective.
Supporting staff with their health and well-being	<ul style="list-style-type: none"> Routine review of staff risk assessments and the arrangements in place to support staff within the high risk/vulnerable category. Continue to provide support for staff to work from home for extended periods and ensure all staff are provided a safe workplace where necessary and appropriate. Recruitment of additional clinical/nursing/scientific/support staff to increase our resilience Identify any further digital tools we could deploy to support flexible working for staff. Maintain staff wellbeing services including HR helpline and employee assistance programme to support staff in their work/personal lives and supplement as appropriate. Review policies required to support services for elongated period of COVID-19 resurgence e.g. carry over leave for 2 years
Explaining what we are doing and why	<ul style="list-style-type: none"> Ensure agile communications with donors and patients to enable them to access services during this period; especially in times of increased community transmission and local/national lock-downs Continue to listen to patients, donors and families about what more we can do to support them during this difficult period Work in partnership with the Community Health Council(s) to explain any changes we wish to make for the benefit of the people we serve Enhanced use of internet and social media to communicate key national messages and those specific to cancer services and blood and transplant services.



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TRUST BOARD PART A

TRUST ASSURANCE FRAMEWORK UPDATE

DATE OF MEETING	26 TH November 2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report	
PREPARED BY	Lauren Fear, Director Corporate Governance	
PRESENTED BY	Lauren Fear, Director Corporate Governance	
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director Corporate Governance	
REPORT PURPOSE	FOR DISCUSSION / REVIEW	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Strategic Development Committee	5/11/20	IN SUPPORT
ACRONYMS		
TAF	Trust Assurance Framework	

1. PURPOSE

- 1.1 The purpose of this paper is to provide the Board with an update on the development of Velindre University NHS Trust's Trust Assurance Framework, and in particular an opportunity for members to discuss and input into proposed Trust Assurance Framework candidate risks, as identified through risk workshops with the executive team.
- 1.2 Members are asked to **NOTE** the update, and **REVIEW** the proposed draft Trust Assurance Framework risks, considering whether they accurately reflect the principal risks to the achievement of the Trust's strategic objectives and goals in light of current climate and operating environment challenges.

2. BACKGROUND

- 2.1 In November 2019 Audit Wales/ Auditor General for Wales submitted their 'Structured Assessment' of Velindre University NHS Trust, recommending that the Board review its principal risks to the achievement of strategic priorities and ensure that necessary assurances have been mapped and reflected in a new Board Assurance Framework (BAF).
- 2.2 The Executive Team were keen to embed a way of working that 'means something' for staff bottom-up, i.e., that provides visibility on strategic, major programme and operational risk across the Trust, empowering employees to ask questions and raise concerns, as well as providing an assurance mechanism for the Board. To ensure a Trust-wide focus is applied to risk management, the recommendation was expanded into a Trust Assurance Framework (TAF), reflecting that the Trust is on a journey towards creating a risk-aware culture top-down and bottom-up.
- 2.3 In practice this means that the Trust's new Trust Assurance Framework will consist of the top approximately 10 risks (best practice is approximately 10 and should not be more than 15) threatening its viability, made up of:
 - Principal and strategic risks, i.e., those that could close down a service/services, seriously prejudice or threaten achievement of a principal or strategic objective, threaten the safety of service users, threaten the reputation of the Trust, lead to significant financial imbalance and/or the need to seek additional funding to enable resolve and/or result in significant diversion of resources from another aspect of the organisation;
 - Major programme risks that might affect the organisation's ability to deliver on its strategic plan; and/or any
 - Material business and operational risks that might affect the organisation's ability to execute its statutory obligations, i.e., significant risks, typically impacting multiple divisions/departments and relating to: business interruption, errors or omissions by employees, process failure, health and safety and clinical risks, failure of IT systems, fraud, loss of key people, litigation, and/or loss of key suppliers.

2.4 Work has been undertaken to refresh the Trust Assurance Framework and the new Framework was approved in the Trust Board in September 2020. Alongside this work to refresh the Framework, several strategic risk identification workshops were carried out across the Trust during July and August to determine suitable candidate risks for inclusion in the Trust Assurance Framework.

2.5 The following workshops were held with the relevant Executive Lead and members of their senior teams:

Division/ Professional overlay	
1.	Strategy
2.	Velindre Cancer Centre (VCC)
3.	Welsh Blood Services (WBS)
4.	Transforming Cancer Services (TCS)
5.	Finance
6.	Workforce & Organisational Development (OD)
7.	Charity
8.	Nursing
9.	Medical

2.6 To provide some further context on the workshops, they had a dual purpose. Firstly to identify strategic risks for inclusion in the Trust Assurance Framework and secondly to also to provide a refreshed view of all key risks which will be incorporated into the refreshed view of the Trust Risk Register. The refreshed content for the Trust Risk Register is being reviewed and governed in parallel. At the November Board, the Board will be receiving an update on the refreshed content for both the Trust Assurance Framework, as per this paper, and the Trust Risk Register.

3. KEY THEMES

3.1 Proactive engagement, a high quality of debate, and constructive and open exchange were had during workshops, and a total of **nine** new principal and strategic risks were identified for potential inclusion in the new Trust Assurance Framework. To help facilitate further discussion, indicative risk descriptions for each risk are suggested in the Table below. N.B., These descriptions should not be considered final and will require further improvement and specificity by agreed risk owners:

3.2 Proposed Trust Assurance Framework Candidate Risks:

#	Risk Theme / Title	Draft Risk Description
1	Demand and Capacity	Failure to adequately model demand and/or risk that manageable demand outstrips capacity leading to deterioration and/or inertia in quality, financial and/or operational performance.
2	Partnership Working / Stakeholder Engagement	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
3	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.
4	Organisational Culture	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.
5	Organisational change / 'strategic execution risk'	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
6	Quality & Safety Risk – Holistic Service	Risk that our existing clinical model, systems and/or processes (including failures to learn from patient feedback i.e., patient satisfaction survey / external patient surveys / complaints and failures in ability to gain insight from robust datasets) do not effectively minimise the risk of quality and safety failures and enable us to intervene appropriately when failures occur, which could reduce the confidence of the public, patients/donors, external agencies, regulators and commissioners in the quality of care the Trust provides.
7	Digital transformation - failure to embrace new technology	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
8	Investment	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.
9	Future Direction of Travel	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.
10	Governance	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.

- 3.3. Members are asked to **DISCUSS** the risks proposed in Table above and **CONFIRM** whether they represent the top principal and strategic risks impacting the Trust's goals and objectives.

4. NEXT STEPS

- 4.1 To support the Board to visualise what the final Trust Assurance Framework will look like, a draft Trust Assurance Framework Summary Dashboard is attached at Appendix A, and detailed principal risk dashboards are attached in Appendix B.
- 4.2 Key milestones and next steps are:
- Further engagement with the Executive Team on the proposed overall shape of the refreshed content of the draft Trust Assurance Framework.
 - Agreement with the Executive Management Team of the owners of each of the draft Trust Assurance Framework risks.
 - Paper to the Executive Management Board “Shape the Organisation” in early December, with the further developed draft content of the Trust Assurance Framework.
 - Fully developed content to be brought Strategic Development Committee in December for assurance purposes – and on-going at each Strategic Development Committee going forwards.
 - Fully developed content to be brought to Trust Board in January for approval purposes – and on-going at each Trust Board meeting going forwards.
 - Trust Assurance Framework content to be reviewed at least annually and/or also at points at which the strategic plan for the organisation is refreshed.

5. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined 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



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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.

6. RECOMMENDATION

6.1 Trust Board is asked to:

- (a) Note the update;
- (b) Discuss the draft risks to form part of the newly approved Trust Assurance Framework. This discussion has the aim of firstly providing Trust Board with assurance on the progress being made to develop the content and secondly to also to benefit from the insight and expertise of the wider Board on the proposed draft strategic risks.



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TRUST BOARD

VUNHST EU TRANSITION HIGHLIGHT REPORT

DATE OF MEETING	26/11/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Laurie Thomas – Head of Validation & Risk Management
PRESENTED BY	Alan Prosser – Interim Director WBS
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR DISCUSSION / REVIEW
-----------------------	-------------------------

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

ACRONYMS	
BC	Business Continuity
EP	Emergency Preparedness
VUNHST	Velindre University NHS Trust

1. SITUATION/BACKGROUND

This paper is written to capture the business continuity planning and resilience activities that have been initiated to provide Board assurance around EU Exit and EU Transition.

Since September 2018, there has been significant focused efforts within Velindre University NHS Trust (VUNHST) to ensure there are adequate preparations in place for when the UK leaves the EU. To minimise any disruption, delays or inability for VUNHST to provide the full range of treatments and services if the government fails to achieve a withdrawal agreement.

On 23/01/2020, the UK's EU Withdrawal bill became law, and the UK officially left the EU on 31/01/2020. Following this date, an 11-month Transition phase will run to 31/12/2020.

The VUNHST Business Continuity & Emergency Preparedness Group discuss the Trust assurance position for preparations of EU Exit and Transition at each monthly meeting. This risk position and impact to core service delivery and programmes (including TCS) has been reviewed throughout the Transition period, as and when the key milestones are reached.

As we near the end of the Transition period, the VUNHST BC & EP group has requested the establishment of a weekly Brexit Task and Finish group (from Nov 2020) to coordinate and monitor progression of actions and to provide further assurance in line with how the situation evolves.

Dr. Andrew Goodall (WG) has previously written to all NHS Chief Executives and Directors of Social Services within Wales to inform that the likelihood of a deal situation at the end of the Transition period has not reduced. In line with NHS Confed/WG requests, the Trust has reviewed its position in light of a parallel impact of Covid-19 pandemic.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Brexit SRO (Director of Strategic Transformation, Planning & Digital) continues to provide VUNHST BC & EP and Brexit T&F group chairs with feedback on the Health & Social Services Brexit SRO meeting papers. All risk assessments and VUNHST management action plan have been reviewed in light of the parallel impact of the Covid-19 pandemic.

The most significant risks remain continuity of supplies of medicines, medical devices and clinical consumables (MDCC) and non-clinical goods into the care sector. The current VUNHST risk position has increased to Critical on consideration of the following:-

- The final month for Britain to request an extension of its Transition period beyond 2020 has now past (June 2020). A Trade Deal agreement must be in place by 26/11/2020. As of 12/11/2020, no deal has been reached.

- Additionally, there is increased concern around the supply chain for PPE due to the Covid-19 pandemic.

The associated risk assessment (Ref 14860) captures a high-level overview of the controls that have introduced to mitigate against the identified risks.

Contingency arrangements to minimise the effects of any disruption will be maintained for the immediate future and reviewed and revised following consultation with WG recommendations.

The following actions have been taken to assist with monitoring and managing the Trust position:-

- The VUNHST response to EU Transition is being monitored and reported through the established command structure, i.e. Bronze, Silver Gold and reported by exception on a weekly basis. include updates from COVID-19 cells, Track & Trace, PPE, Social Distancing, Workforce and Quality & Safety.
- Review of Programme Brexit Risks alongside the EU Exit and Transition landscape and the potential impact that this could have on the Programme and Projects.
- Continued engagement in UK groups
- Continued engagement with NWSSP & NWIS
- Continue to review political situation regarding likelihood of a 'No Deal'
- Future Engagement with Welsh Government to determine funding support of financial consequences that cannot be met from within existing allocations, identified through Velindre UNHS Trust monitoring.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Relating to continuity of core business.



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RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Civil Contingencies Act 2004 legislation.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Financial implications are captured within the risk assessment Ref 14860.

4. RECOMMENDATION

4.1 The Board are asked to note the activity to date and accept the revised risk assessment (Ref 14860).

Risk Domain: Performance & Service Sustainability Risk Ref: 14860		Director Lead: Director Strategic Transformations Assuring Committee: Planning & Performance Committee	
Risk: Brexit– Disruption, delays or inability to provide full range of treatments and services if the government fails to achieve a withdrawal agreement when the UK leaves the EU.		Date Added to Register: 17/10/18	Date Last Reviewed: 12/11/2020

<div><div><div>Risk Rating</div><div>(impact x likelihood)</div><table><tr><td>Initial</td><td>4x4</td><td>16</td></tr><tr><td>Current</td><td>4x4</td><td>16</td></tr><tr><td>Target</td><td>3x1</td><td>3</td></tr></table><div>Risk Appetite:</div><div>Nil</div></div></div>	Initial	4x4	16	Current	4x4	16	Target	3x1	3	<div><div><div><div>Risk Rating</div><table><caption>Risk Rating Data</caption><tr><th>Month</th><th>Risk Rating</th><th>Target</th></tr><tr><td>Oct-18</td><td>16</td><td>3</td></tr><tr><td>Nov-18</td><td>16</td><td>3</td></tr><tr><td>Dec-18</td><td>16</td><td>3</td></tr><tr><td>Jan-19</td><td>12</td><td>3</td></tr><tr><td>Feb-19</td><td>12</td><td>3</td></tr><tr><td>Mar-19</td><td>12</td><td>3</td></tr><tr><td>Apr-19</td><td>12</td><td>3</td></tr><tr><td>May-19</td><td>12</td><td>3</td></tr><tr><td>Jun-19</td><td>12</td><td>3</td></tr><tr><td>Jul-19</td><td>12</td><td>3</td></tr><tr><td>Aug-19</td><td>12</td><td>3</td></tr><tr><td>Sep-19</td><td>16</td><td>3</td></tr><tr><td>Oct-19</td><td>16</td><td>3</td></tr><tr><td>Nov-19</td><td>16</td><td>3</td></tr><tr><td>Dec-19</td><td>16</td><td>3</td></tr><tr><td>Jan-20</td><td>8</td><td>3</td></tr><tr><td>Feb-20</td><td>8</td><td>3</td></tr><tr><td>Mar-20</td><td>8</td><td>3</td></tr><tr><td>Apr-20</td><td>8</td><td>3</td></tr><tr><td>May-20</td><td>8</td><td>3</td></tr><tr><td>Jun-20</td><td>8</td><td>3</td></tr><tr><td>Jul-20</td><td>12</td><td>3</td></tr><tr><td>Aug-20</td><td>12</td><td>3</td></tr><tr><td>Sep-20</td><td>12</td><td>3</td></tr><tr><td>Oct-20</td><td>12</td><td>3</td></tr><tr><td>Nov-20</td><td>16</td><td>3</td></tr></table></div></div></div>	Month	Risk Rating	Target	Oct-18	16	3	Nov-18	16	3	Dec-18	16	3	Jan-19	12	3	Feb-19	12	3	Mar-19	12	3	Apr-19	12	3	May-19	12	3	Jun-19	12	3	Jul-19	12	3	Aug-19	12	3	Sep-19	16	3	Oct-19	16	3	Nov-19	16	3	Dec-19	16	3	Jan-20	8	3	Feb-20	8	3	Mar-20	8	3	Apr-20	8	3	May-20	8	3	Jun-20	8	3	Jul-20	12	3	Aug-20	12	3	Sep-20	12	3	Oct-20	12	3	Nov-20	16	3	<div><div><div>Rationale for current score</div><div>On 23/01/2020, The UK’s EU Withdrawal bill became law. The UK officially left the EU on 31/01/2020. An 11-month transition phase will run to 31/12/2020. This risk position and impact will be reviewed throughout the transition period, as and when the key milestones are reached.</div><div>In line with NHS Confed/WG, the Trust is being asked to consider the risk in light of a parallel impact of Covid-19 pandemic.</div><div>The current risk position has increased on consideration of the following:-<ul style="list-style-type: none">- The final month for Britain to request an extension of its transition period beyond 2020 has now past (June 2020). A Trade Deal agreement must be in place by November 26th 2020. As of 12/11/2020, no deal has been reached.- Additionally, there is increased concern around the supply chain for PPE due to the Covid-19 pandemic.</div><div>Contingency arrangements to minimise the effects of disruption will be maintained for the immediate future & reviewed and revised following consultation with WG recommendations.</div></div></div> <div><div><div>Rationale for target score</div><div>Risk appetite is Nil and the Trust objective would be to maintain services at the level pre Brexit.</div></div></div> <div><div><div>Groups reviewed risk during period</div><div>EMB</div></div></div>
Initial	4x4	16																																																																																										
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<div><div><div>What controls have we put in place for the risk:</div><div><div>Corporate/Trust Wide</div><div><div>1. Workforce planning - Staff supported to apply for settled status. The Home Office is currently continuing its engagement with employers to shape the future immigration system which will be in place for the recruitment of European Economic Area (EEA) and non-EEA citizens from 1 January 2021. The risks identified for a no-deal Brexit have recently been revised in light of COVID-19 as at 30th June 2020 (extension to transition period)</div><div>2. The UK Government is putting in place plans to ensure the supply of medical devices and clinical consumables.</div><div>3. The current OJEU legislation of fairness, transparency and equal treatment will prevail. The engagement with EU entities will largely depend on the content of any trade agreements that are negotiated with the EU.</div><div>4. All Wales procurement services provided by NWSSP for NHS Wales via contingency stock warehouse (IP5).</div></div></div></div></div>	<div><div><div>What actions should we take:</div><table><tr><th>Action</th><th>Lead</th><th>Date</th></tr><tr><td>Monitor and review position within Velindre UNHS Trust BC meetings include updates from COVID-19 cells, Track & Trace, PPE, Social Distancing, Workforce and Quality & Safety.</td><td>Chief Operating Officer, Directors VCC & WBS</td><td>On-going</td></tr><tr><td>Continued engagement in UK groups.</td><td>Directors VCC & WBS</td><td>On-going</td></tr><tr><td>Continued engagement with NWSSP & NWIS.</td><td>Director of Strategic Transformation, Planning & Digital, Directors VCC & WBS</td><td>On-going</td></tr><tr><td>Continue to review political situation regarding likelihood of a ‘No Deal’.</td><td>Director of Strategic Transformation, Planning & Digital</td><td>On-going</td></tr></table></div></div>	Action	Lead	Date	Monitor and review position within Velindre UNHS Trust BC meetings include updates from COVID-19 cells, Track & Trace, PPE, Social Distancing, Workforce and Quality & Safety.	Chief Operating Officer, Directors VCC & WBS	On-going	Continued engagement in UK groups.	Directors VCC & WBS	On-going	Continued engagement with NWSSP & NWIS.	Director of Strategic Transformation, Planning & Digital, Directors VCC & WBS	On-going	Continue to review political situation regarding likelihood of a ‘No Deal’.	Director of Strategic Transformation, Planning & Digital	On-going																																																																												
Action	Lead	Date																																																																																										
Monitor and review position within Velindre UNHS Trust BC meetings include updates from COVID-19 cells, Track & Trace, PPE, Social Distancing, Workforce and Quality & Safety.	Chief Operating Officer, Directors VCC & WBS	On-going																																																																																										
Continued engagement in UK groups.	Directors VCC & WBS	On-going																																																																																										
Continued engagement with NWSSP & NWIS.	Director of Strategic Transformation, Planning & Digital, Directors VCC & WBS	On-going																																																																																										
Continue to review political situation regarding likelihood of a ‘No Deal’.	Director of Strategic Transformation, Planning & Digital	On-going																																																																																										

<p>5. Management action plan being redrafted to reflect current understanding of risk profile across VUNHST.</p> <p>6. Many fixed price agreements in place across the divisions for key services/ equipment.</p> <p>7. Contingency exercises planning events have taken in place for WBS, VCC, NWIS and NWSSP.</p> <p>8. Website launched with internal / external information for patients/donors/partners and staff on issues related to Brexit. Continuing to update as new developments surface.</p> <p>9. A separate risk assessment has been undertaken to consider the specific issues around the provision of Personal Protective Equipment (PPE) in light of COVID-19 and Brexit. The international PPE market and supply into the UK could be impacted by Brexit, but only for European based manufacture which does not make up the bulk of manufacturing. Mitigated by daily stock monitoring, critical stock uplifted and mutual aid from LHBs and Trusts.</p> <p>10. A separate risk assessment is underway on the Transforming Cancer Services (TCS) programme and project risk revision post COVID-19 and Brexit.</p> <p>11. Public Contract Regulations in place.</p> <p>12. Financial consequences at an organisation and national level are monitored at Directors of Finance regular meetings, to determine any funding flows above planned inflationary levels.</p> <p>13. Continuing to closely work with commercial and non-commercial sponsors that carry the liability for the ongoing conduct of RD&I studies hosted within the organisation. This ensures that the risk profile of the Trust is not compromised. Studies sponsored by the Trust have been risk assessed and outcomes actioned with all relevant stakeholders to ensure ongoing compliance with the appropriate legislative and regulatory requirements at this time and into the future.</p> <p>VCC</p> <p>14. Divisional risk assessments undertaken and regularly reviewed. The VCC risk assessment has been reviewed in light of the COVID-19 pandemic and changes in demand profile.</p> <p>15. Review of critical supplier lists within service division completed.</p> <p>16. Work ongoing on supply chain at VCC.</p> <p>17. Undertake/review departmental Business Impact Analysis to identify key risk areas within Service division completed.</p> <p>18. Services have identified range of contacts with EU suppliers and assessed delivery confidence.</p> <p>19. Detailed assessment on supply chain relating to radiopharmaceuticals which is recognised as a risk area by Regulatory Bodies and WG.</p> <p>20. Memorandum of Understanding with SBHB for provision of radiotherapy in the event of mutual support required.</p> <p>21. Contractual agreement with Rutherford Cancer Centre (RCC) for provision of radiotherapy in the event of additional capacity being required.</p> <p>22. Maximised critical inventory stock.</p> <p>23. Review contracts and discuss critical impact points with individual suppliers and contractors.</p> <p>24. Services have identified range of contacts with EU suppliers and assessed delivery confidence.</p> <p>25. Service has identified critical Service Level Agreements (SLA's) with Health Board's and assessed delivery confidence.</p> <p>WBS</p> <p>26. Divisional risk assessments undertaken and regularly reviewed. The WBS risk assessment has been reviewed to consider impact post COVID-19.</p> <p>27. Memorandum of Understanding (MOU) with UK & Ireland Blood establishments (extended to include consumables and blood components).</p> <p>28. Joint Professional Advisory Committee will consider derogations to Regulations if critical blood supply chain issues arise.</p> <p>29. Human Tissue Authority (HTA) produced statutory instrument for import and export of tissues and cells.</p>	<p>Future Engagement with Welsh Government to determine funding support of financial consequences that cannot be met from within existing allocations, identified through Velindre UNHS Trust monitoring.</p>	<p>Director Finance</p>	<p>On-going</p>
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30. Review of critical supplier lists within service division completed and under regular review for alignment to service operation and provision to customer hospitals. 31. Maximised critical inventory stock including PPE requirements 32. Review contracts and discuss critical impact points with individual suppliers and contractors. 33. Review of critical equipment maintenance programmes. 34. Undertake/review departmental Business Impact Analysis to identify key risk areas within Service division completed. 35. Services have identified range of contacts with EU suppliers and assessed delivery confidence. 36. Reviewed data flows for assurances on continuity. 37. On-going review of Regulatory position and analysis of impact to service provision.	
Additional Comments: 38. VCC and WBS have completed full risk assessments; under regular review as more information becomes available. 39. The hosted organisations have completed risk assessments & provided assurance that these are under regular review as more information becomes available. 40. Regular meetings of the VUNHST Business Continuity & Emergency Preparedness Group and engagement in national groups continues. 41. Established weekly Brexit T&F group as of November 2020.	

Appendix 1

Risk Appetite Levels

Appetite Level	Described as:
None	Avoid - The avoidance of risk and uncertainty is a key organisational objective.
Low	Minimal - Preference for ultra-safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Moderate	Cautious - Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	Open - Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM).
Significant	Seek - Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk. Mature - Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Risk Matrix

	LIKELIHOOD				
IMPACT	Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
5 Catastrophic	25	20	15	10	5
4 Major	20	16	12	8	4
3 Moderate	15	12	9	6	3
2 Minor	10	8	6	4	2
1 Insignificant	5	4	3	2	1
Risk Score	Risk Level		Action and Timescale		
1-3	LOW		No action required providing adequate controls in place.		
4-6	MODERATE		Action required to reduce/control risk within 12 month period		
8-12	SIGNIFICANT		Action required to reduce/control risk within 6 month period		
15-25	CRITICAL		Immediate action required by Senior Management		

TRUST BOARD

REMUNERATION COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	26.11.2020
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Director of Organisational Development and Workforce
REPORT PURPOSE	FOR NOTING
ACRONYMS	
VCC	Velindre Cancer Centre

1. PURPOSE

- 1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by the Remuneration Committee on 22.10.2020.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.



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2. HIGHLIGHT REPORT

ALERT / ESCALATE	<ul style="list-style-type: none">Nothing of note to report
ADVISE	<p>Chair's Urgent Action</p> <ul style="list-style-type: none">The committee endorsed a Chair's urgent action in respect of redundancy payments for two NWIS employees. <p>Redundancy Payment</p> <ul style="list-style-type: none">The committee approved a redundancy payment for one employee.
ASSURE	<ul style="list-style-type: none">Nothing of note to report
INFORM	<p>Board Level Appointments</p> <ul style="list-style-type: none">The committee approved the remuneration for a Board Level appointment. <p>Update on Pay Awards</p> <ul style="list-style-type: none">The committee noted an update on pay awards for 2020/21
APPENDICES	<p>NOT APPLICABLE</p>



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TRUST BOARD

QUALITY SAFETY AND PERFORMANCE COMMITTEE – DIVISIONAL PERFORMANCE AS AT SEPTEMBER 2020

DATE OF MEETING	26/11/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Peter Gorin, Head of Corporate Strategic Planning and Performance
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PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
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EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer
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REPORT PURPOSE	FOR DISCUSSION / REVIEW
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME
Quality Safety and Performance Cttee	12 th Nov 2020	DISCUSSED & NOTED

ACRONYMS

VUNHST	Velindre University NHS Trust
UHB	University Health Board

VCC SMT	Velindre Cancer Centre Senior Management Team
WBS SMT	Welsh Blood Service Senior Management Team
PADR	Performance Appraisal and Development Review
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board

1. SITUATION/BACKGROUND

- 1.1 The attached Trust performance reports are intended to provide an update to the Trust Board with respect to Trust-wide performance against key performance metrics.
- 1.2 The attached reports describe performance through to the end of September 2020 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 The reports set-out performance at Velindre Cancer Centre (**appendix 1**), the Welsh Blood Service (**appendix 2**) and in relation to Trust-wide staff absence, PADR compliance and staff sickness (**appendix 3**). Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance across the Trust. A number of areas from these reports is highlighted below.
- 2.2 The divisional performance reports were initially presented to the WBS and VCC Senior Management Teams (SMTs) and have been reviewed by the new Quality, Safety and Performance Committee at their meeting held on 12th November 2020.
- 2.3 **Velindre Cancer Centre:**
Our cancer services have been severely disrupted as a result of COVID-19, and there has been a requirement to centralize the majority of our services from other hospital sites across the region to the Velindre Cancer Centre.

Operational constraints required to ensure social distancing and other infection control measures have exacerbated these challenges, in respect to Outpatient services and SACT. This rapid migration to a centralized model was required to support the All-Wales objective of maintaining COVID-19 free sites where possible and to contribute to regional COVID-19 capacity requirements.

However, working in partnership with Cwm Taf Morgannwg UHB, the VCC SACT service has facilitated the partial reopening of the Macmillan Unit at Prince Charles Hospital in early September with the UHB pharmacy services supporting pharmaceutical manufacture for VCC SACT services. VCC has also engaged with Aneurin Bevan UHB with respect to the reinstitution of outreach services, with UHB pharmacy services again supporting in the provision of VCC SACT services.

2.3.1 Cancer services

The reactivation of deferred patients has had a significant impact on SACT services in particular and during Quarter 2 has resulted in extended lengths of wait, given the reactivation numbers and the significantly reduced capacity, however this was managed with a clinical prioritization plan.

The pressure on outpatient services has been significant due to the centralization of all outreach services into VCC, alongside the social distancing challenge. This has been compounded by the lack of local Phlebotomy provision at UHBs and GP practices, which has resulted in significant increase in patients attending VCC.

Physical capacity at VCC has been reduced by 30-40% as a result of the requirement to comply with social distancing and infection prevention guidelines and policies. There are ongoing discussions regarding options to increase capacity at VCC for SACT and Radiotherapy.

2.3.2 Patient Feedback

Decrease in performance against key waiting times and patient experience feedback areas demonstrate the impact of COVID-19 (implementation of virtual consultations at pace, clinical activity centralized at VCC from outreach settings, etc.) on the workforce availability and physical site capacity.

Patient feedback via surveys or complaints has been consistent in some areas, such as administrative arrangements for virtual clinics, phlebotomy appointments and outside shelter. The areas discussed at the VCC Quality and Safety Management Group (QSMG) demonstrate awareness of the issues and that plans are in progress to improve these areas.

Whilst it has not been possible to triangulate the specific indicators against services or departments, service specific performance meetings have been implemented where such data and information is discussed and challenged resulting in improvement plans.

2.4 Welsh Blood Service

Supply of all blood components to meet demand has been sustained in difficult operating environment. We are continuing to experience difficulties in booking blood collection venues as businesses return to use their facilities and introduce new Covid restrictions.

There are also ongoing staff capacity challenges that have been created from staff isolation and the risk assessment for shielding staff. We are continuing to work through this with WOD colleagues to ensure safe and effective working and maintenance of the blood supply chain.

2.4.1 Whole Blood Collection Efficiency (Target 1.25 units by WTE per hour)

Collection efficiency is below the target at 1.11 as consequence of the ongoing need to increase resource requirements due to COVID 19, which has resulted in additional staffing being sent out per team to man a newly added triage point, and to support the introduction of social distancing and PPE. Depending on the number of chairs put out, this could see an increase of up to 3 staff per team. This is likely to continue for the long term while COVID 19 is present within the community. However a small improvement has been seen due increase in collections to meet demand and this has been sustained improvement for the past 3 months.

The changes which were due to be brought in under the Blood Supply Chain 2020 have been put on hold during the COVID 19 pandemic.

2.4.2 Manufacturing Efficiency

Production efficiency continues to remain below what we would expect. The principal influences on this are lower collections due to current COVID conditions and increased staffing in line with recruitment to ambient overnight hold.

This position and the target to be reviewed in line with processing staff changes as part of the Blood Supply Chain 2020 initiative.

2.4.3 Time Expired Platelets (Target 10% expired)

Time expired platelets was above target for September at 25.29% This is as a result of increased production to cover the bank holiday at the end of August and in the third week

following reduced demand. Overall wastage was down compared to previous months (except August) but production has also been reduced so the % wastage increased.

Further planned reduction in platelet production will continue. This will be an iterative implementation over a period of time that will continue to be impacted on by external factors and as such does not have a definitive deadline.

2.4.4 Donor Feedback

WBS invites every blood donor to complete a feedback survey in the month after their donation. This is available online, by text message or by completion of a feedback form. 3680 emails successfully sent and 1371 completed responses (37.3% response rate) were received

Overall donor satisfaction for the month of September continued to exceed target position at 96% with 1,059 (77% of the completed responses) donors rated the service six out of six.

However, a small number of respondents who scored their satisfaction as one (11 respondents) or two (9 respondents) out of six, were offered the opportunity to provide qualitative feedback and action relating to these issues is being collated.

2.5 Corporate Services

2.5.1 PADR Compliance (Target 85%)

Compliance rates have decreased to 66.25 % as a result of COVID-19 operational impacts. Going forward there will be a focus on improved recording with guidance on PADR completion and triangulation of data in hotspot areas of poor PADR compliance to ensure data provides effective information on the issues.

2.5.2 Sickness Absence (Target 3.54%)

Sickness absence remains above target at 5.23%. A template to improve reporting to Heads of Department is being developed by end of November, sharing monthly sickness absence data to encourage local and timely conversations, identify 'hotspots' and trends, to ensure that the proactive wellbeing approach is embedded within management practice.

It is noted that the Chair and Members have requested:

- an update on the wellbeing space for staff
- analysis to understand the root causes of the sickness
- and impact of COVID on sickness and separating data on shielding

Work is currently underway to respond to these issues.

2.5.3 Mandatory and Statutory Compliance (Target 85%)

Mandatory and Statutory Focus Group set up to share best practice and improve compliance, currently at 80.57%. The Group membership includes Trust trainers and Subject Matter Experts who will produce training needs analyses, identifying levels needed for each staff group and what is mandatory and this now includes COVID related training.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: <ul style="list-style-type: none"> • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

4. RECOMMENDATION

- 4.1 The Velindre University NHS Trust Board is asked to **DISCUSS** and **REVIEW** the contents of the attached performance reports.



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VELINDRE CANCER CENTRE DIVISIONAL REPORT – September 2020

DATE OF MEETING	26 th November 2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable	
PREPARED BY	LISA MILLER, DIRECTOR OF OPERATIONS	
PRESENTED BY	Paul Wilkins, Director of Cancer Services	
EXECUTIVE 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
ACRONYMS		
ABUHB	Aneurin Bevan University Health Board	
BAU	Business As Usual	

BCUHB	Betsi Cadwaldr University Health Board
BI	Business Intelligence
BEM	British Empire Medal
CAT	Cancer Associated Thrombosis
CDG	All Wales Care Decisions for the Last Days of Life guidance
CHC	Community Health Council
CT	Computerised Tomography
CTSF	Core Training Skills Framework
DGH	District General Hospital
DNARCPR	Do Not Attempt Cardiopulmonary Resuscitation
DOLs	Deprivation of Liberty Standards
DPD	Dihydropyrimidine dehydrogenase
DTOC	Delayed Transfer of Care
EMB	Executive Management Board
ESR	Electronic Staff Record
FBC	Full Business Case
HAT	Hospital Acquired Thrombosis
HCS	Healthcare Standards
HIW	Health Inspectorate Wales
IMTP	Integrated Medium Term Plan
IPCT	Infection Control and Prevention Team

IR(ME)R	Ionising Radiation (Medical) Exposure Regulations
KPI	Key Performance Indicator
LTS	Long Term Sickness
MARS	Medical Appraisal and Revalidation System
MDT	Multidisciplinary Team
NCEPOD	National Confidential Enquiry for Patient Outcome and Death
nUSC	non-Urgent Suspected Cancer
OPD	Outpatients
PADR	Performance Appraisal and Development Review
PCH	Prince Charles Hospital
PMO	Programme Management Office
PHW	Public Health Wales
PPE	Personal Protective Equipment
PREM's	Patient Reported Experience Measures
PROM's	Patient Reported Outcome Measures
PTR	Putting Things Right
QSMG	Quality and Safety Management Group
QSP	Quality, Safety and Performance
RMG	Radiotherapy Management Group
SACT	Systemic Anticancer Therapy
SaFF	Service and Financial Framework

SBUHB	Swansea Bay University Health Board
SCIF	Significant Clinical Incident Forum
SCP	Single Cancer Pathway
SMT	Senior Management Team
SOP	Standard Operating Procedure
SST's	Site Specific Teams
SSF	Site Strategic Group
ST	Short term Sickness
SWCN	South Wales Cancer Network
US	Unscheduled Care
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WFH	Working from Home
WCP	Welsh Clinical Portal
WG	Welsh Government
WNCR	all-Wales Welsh Nursing Care Record
WOD	Workforce and Development
WTE	Whole Time Equivalent

1. SITUATION

1.1 This paper is to provide Trust Board with an update on the key quality, safety and performance outcomes and metrics for Velindre Cancer Centre for the period 1st – 30th September 2020.

1.2 The Trust Board is asked to **DISCUSS and REVIEW:**

- progress against the key priority areas
- issues, corrective actions and monitoring arrangements in place
- identify opportunities for learning and best practice

2. BACKGROUND

2.1 This report is a summary of the key operational, quality, safety and performance related matters for Velindre Cancer Centre (VCC) during September 2020. The report has been prepared in readiness for the newly defined Velindre University NHS Trust (VUNHST) Board and Committee governance arrangements.

2.2 The report attempts to highlight key programmes of work underway, performance against indicators, key workforce activities, patient feedback, improvement plans and organisational/individual successes.

2.3 Cancer services have been severely disrupted as a result of COVID-19. The causes, specific to cancer services are summarised below:

- Patients being reluctant to present to primary care and secondary care tests/treatments, driven by the perceived risks of C-19 infection and/or an unwillingness to burden the NHS
- The pausing of cancer screening programmes
- Some services such as rehabilitation being stopped because the workforce has been diverted to respond to the C-19 pandemic
- Reduced efficiency and capacity due to C-19 precaution measures and managing patients with C-19
- Managing clinical staff impacted by track and trace contact
- Some diagnostic tests and a number of treatments being stopped or deferred due to the risks of C-19 infection outweighing their benefits.

2.4 Throughout quarter 1 and 2 VCC maintained the delivery of essential services with patient whose treatments were deferred being restarted in Q2 as appropriate. A comprehensive review of those services was undertaken to ensure that the identified service transformations implemented in response to COVID-19 which

should be maintained are aligned with our pre-COVID-19 service development plans and strategic intent.

- 2.5 There has been a requirement to centralise the majority of our services from other hospital sites across the region to the Velindre Cancer Centre. This rapid migration to a centralised model was required to support the All-Wales objective of maintaining COVID-19 free sites where possible and to contribute to regional COVID-19 capacity requirements.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 3.1 The main report provides a summary detail of;

- Key performance indicators and associated improvement actions
- Outline of key quality and safety indicators and remedial actions required
- An assessment of COVID related activities, risks and mitigation
- Patient and Carer Feedback alongside improvement actions
- Workforce performance metrics
- Regulator and audit feedback
- Critical and Significant Trust/Divisional Risks
- Assurance and learning themes
- Progress against service developments

- 3.2 The reactivation of deferred patients has had a significant impact on Systemic Anti-Cancer Therapy (SACT) services in particular and during quarter 2 has resulted in extended lengths of wait, given the reactivation numbers and the significantly reduced capacity, however this was managed with a clinical prioritisation plan.

- 3.3 The pressure on outpatient services has been significant due to the centralisation of all outreach services into VCC, alongside the social distancing challenge. This has been compounded by the lack of local Phlebotomy provision at Health Boards (HB's) and GP practices, which has resulted in significant increase in patients attending VCC.

- 3.4 Physical capacity at VCC has been reduced by 30-40% as a result of the requirement to comply with social distancing and infection prevention guidelines and policies. There are ongoing discussions regarding options to increase capacity at VCC for SACT and Radiotherapy.

3.5 Triangulated Analysis

- 3.5.1 Decrease in performance against key waiting times and patient experience feedback areas demonstrate the impact of COVID-19 (implementation of virtual consultations at pace, clinical activity centralised at VCC from outreach settings etc) on the workforce availability and physical site capacity.
- 3.5.2 Patient feedback via surveys or complaints has been consistent in some areas such as administrative arrangements for virtual clinics, phlebotomy appointments and outside shelter. The areas discussed at the VCC Quality and Safety Management Group (QSMG) demonstrates awareness of the issues and that plans are in progress to improve these areas.
- 3.5.3 It has not been possible to triangulate the specific indicators against services or departments. However, service specific performance meetings have been implemented where such data and information is discussed and challenged resulting in improvement plans.

3.6 Key Actions / Areas of focus during next period

- 3.6.1 Delivery of Q3 and Q4 service plans including management of 'wave 2' COVID pandemic and winter pressures.
- 3.6.2 Seek to improve levels of patient/carer survey completion.
- 3.6.3 Provide solutions to increase space availability for staff break out space.
- 3.6.4 Improve compliance with review of risks feeding into risk register.
- 3.6.5 Strengthen automation of data required for this report to minimise manual calculations required working with the Business Intelligence (BI) team to enhance analysis capacity.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	<p>If more than one Healthcare Standard applies please list below:</p> <ul style="list-style-type: none"> • Staff and Resources • Safe Care • Timely Care • Effective Care.
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)

5. RECOMMENDATIONS

5.1 The Trust Board are asked to **DISCUSS AND REVIEW** the content of this report.

VELINDRE CANCER CENTRE - TRUST BOARD REPORT

1st September – 30th September 2020

1. INTRODUCTION

- 1.1 This is the first report for the combined Trust Quality, Safety and Performance (QSP) Committee.
- 1.2 The report will continue to evolve following feedback from Committee members and the Velindre Cancer Centre (VCC) Senior Management Team (SMT).
- 1.3 Due to the conflict in meeting dates this report has not received official sign off by the SMT.
- 1.4 The actions detailed below were highlighted as areas for improvement in the August Quality and Safety (QS) report. Below is an update.

Area for Improvement	Actions taken	Monitoring Group	Completion Date
DPD testing prior to chemotherapy (Genetic testing)	<ul style="list-style-type: none"> Formal service improvement project established. Problems identified including increase in consultants and medical secretaries working remotely when the process was designed on the assumption that a hard copy test request would be completed which would then accompany patient to phlebotomy or outreach clinic. The Interim DPD Testing Process went live on 26 May following the training events on 20 May. From October 2020, DPD test results are now available on the Welsh Clinical Portal (WCP). All reported issues and treatment deferrals reviewed in detail to ascertain root cause and if remedial action is required. 	SACT SSG	October 2020 Closed

Area for Improvement	Actions taken	Monitoring Group	Completion Date
<p>Prescribers adhering to the 36 hour rule for chemotherapy</p> <p>(The 36 hour rule is an in-house term which has been developed to explain the minimum amount of time between a prescription being prescribed for a patient and their day case appointment. This time (ie 1 full working day) allows for the prescription to be retrieved, to be clinically checked by a pharmacist, dispensed and checked off AND be on the day case unit BEFORE the patient's appointment is ready. Thus supporting the flow of patients on the day case units and reduce on the day waits)</p>	<ul style="list-style-type: none"> Task and finish group to be established. Group will review compliance, map process and provide improvement recommendations. Promoting use of Datix system to report non-compliance. All prescribers have been reminded of their individual responsibility to adhere to the target. Report developed which will be piloted in OPD during November. This will be used at the end of each clinic for clinicians to review and action upon their outstanding authorisations. Incidents and pilot to be monitored in line with Project timescales. 	SACT SSG	30 th December 2020
Administration and organisation of virtual clinics	<ul style="list-style-type: none"> Standard Operating Procedure (SOP) approved by Outpatient Programme Board and cascaded. All clinics are currently reviewed via the secretary for their consultants to identify the method of consultation. A virtual hub is being established to provide dedicated space for clinicians to operate such clinics. 	OPD Programme Board	September 2020 Closed

Area for Improvement	Actions taken	Monitoring Group	Completion Date
	<ul style="list-style-type: none"> Bookings teams are regularly reminded of the important to select appointment type and that all letters clearly indicate the type of appointment. Daily audits are undertaken on a sample of letters and all staff reminded to check all letters being sent out. All clinicians have been reminded to complete and return clinic outcome forms. These are monitored with non-compliance reported to the Clinical Director, Head of Nursing or Chief Pharmacist as appropriate. Virtual activity is monitored weekly and monthly by the Programme Board. 		
Organisation of phlebotomy service appointments	<ul style="list-style-type: none"> The process of booking appointments for patients requiring blood tests is working well and the services continues to monitor the use of appointments and the workload of the department. Regular communications are sent to booking teams to remind of the processes to be followed and to make use where possible of the evening appointments. The Standard Operating Procedure (SOP) will be approved at the November Outpatient Programme Board meeting. A mobile unit will be utilised in order to streamline the service and reduce overcrowding in the main outpatients department. A longer term solution of relocating the phlebotomy department to another location in VCC is being progressed. The future issues will be managed via the Accommodation Group that reports into the Senior Management Team. 	OPD Programme Board	September 2020 Closed

1.5 **SACT Peer Review**

1.5.1 As outlined in the August report to the Trust Quality and Safety Committee, VCC took part in the South Wales Cancer Network Peer Review (SWCN) in February 2020. The final version of SACT Peer Review Audit was received 24th July 2020. The report is attached in appendix 1.

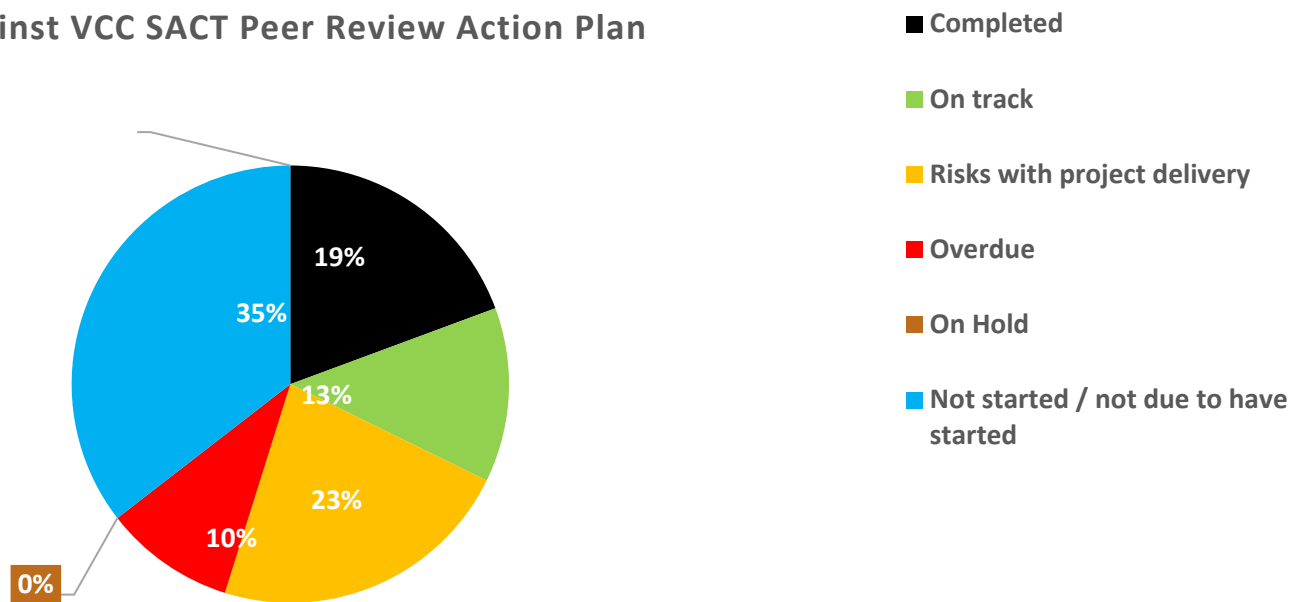
1.5.2 There were NO immediate or serious concerns raised.

1.5.3 **Good Practice and/or Significant Achievements** noted in the report are as follows;

- Excellent education package for nurses
- Demonstrates a collaborative approach to work with primary care
- Allocated resource for scheduling is having a positive impact
- Good quality validated data for performance
- Achieved targets for implementing new drugs
- A good team that are passionate about what they do and work well collaboratively
- All the nurses do an outstanding job, are very supportive and flexible team that put the patients' needs at the centre
- A dedicated patient experience manager, an active patient liaison group and cohort of patient leaders
- A dedicated Trust Complaints Manager

1.5.4 The associated action plan has been developed in line with the suggested areas for improvement and is attached in appendix 1.

Progress against VCC SACT Peer Review Action Plan



2. TRUST BOARD PERFORMANCE REPORT

- 2.1 Velindre Cancer Centre Quality, Safety and Performance Report is under development and will develop in forthcoming months.
- 2.2 The performance report is provided in **appendix 1**.
- 2.3 The majority of VCC targets were met against a backdrop of unprecedented demand, complexity and operational pressures. However it is clear to see the impact COVID-19 has had on VCC and the implications of changes within the wider system.

- 2.4 The organisational emergency response to the COVID-19 pandemic came into effect in late March. There was disruption to patient treatment pathways and activity at Velindre Cancer Centre during that time. A number of actions identified for delivery at the time have been delayed due to the COVID pandemic. These are clearly articulated in the performance report narrative.
- 2.5 Below is a brief summary of the activity levels within outpatients and phlebotomy for September 2020. This demonstrates the increased levels of activity and the ambition to undertaken virtual assessments where appropriate.

Outpatients

		Clinic type group	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Total
Total Virtual Appointment - Video	Virtual	All	877	1412	2740	2614	2165	2507	12315
Total Telephone	Telephone	All	453	401	565	487	401	466	2773
Total Face to Face Appointment	Face to Face	All	3000	2278	1694	2233	2173	2485	13863
Grand Total	Grand Total		4330	4091	4999	5334	4739	5458	28951

Phlebotomy Attendances - are shown for the period April – September 2020:

	2020/21						
	April	May	Jun	Jul	Aug	Sep	Total to date
Phlebotomy Attendances	947	1210	1510	1590	1476	1695	9384

- 2.6 During September there has been a fall in 9 KPI's, 17 remained unchanged and 1 that has improved.

% of patients receiving radical radiotherapy within 28 days				
% of patients receiving palliative radiotherapy within 14 days				
% of patients receiving emergency radiotherapy within 2-days.				
% of patients receiving non-emergency SACT treatment within 21-days.				
% of patients receiving emergency SACT treatment within 5-days.				
Number of VCC acquired potentially avoidable pressure ulcers.				
Number of VCC inpatient falls.				
Number of VCC acquired healthcare associated infections.				
% of patients who receive a diagnosis of sepsis and receive all 6 treatment elements within 1 hour.				
% of patients who rated experience at Velindre as 9 out of 10 or above.				
% of therapies inpatients seen within 2 working days.				
% of urgent therapies outpatient referrals seen within 2 weeks.				
% of routine therapies outpatient referrals seen within 6 weeks.				
% of outpatients seen within 20 minutes.				
% outpatient DNA rates.				
Number of potentially avoidable hospital acquired thrombosis (HAT).				
Number of delayed transfers of care (DToCs).				
Number of pressure ulcers reported to Welsh Governments as serious incidents.				
% clinical coding within 1 month.				

2.7 Deep Dive Assessment: Quality, Performance and Outcomes – By Exception

2.2 Velindre Cancer Centre:

2.2.1 Radiotherapy Waiting Times

VCC continues to operate under its COVID 19 modified service model during this period. Due to the nature of the patient pathways and these service changes, there has been an impact on service performance against waiting times for radiotherapy. September saw 333 referrals for radiotherapy, an increase of 7% on the 310 referrals received in August. None of these patients breached the tier 1 target for 1st definitive treatment and the clinical prioritisation in keeping with the current advice of the Royal College of Radiologists (RCR). The clinical prioritisation process continues to be applied.

There was a reduction in the number of breaches over the August figures for both 28 days and 14 days with 2 day emergency treatments the same.

Radical Radiotherapy target for treatment within 28 days achieved 94% with 13 breaches from a total of 210 treated.

Palliative Radiotherapy target for treatment within 14 days achieved 94% with 6 breaches from a total of 98 treated. Breaches were as a result of reduced Covid related capacity and pre radiotherapy process delays.

2.2.2 Systemic Anti-Cancer Therapy (SACT) treatment

The SACT service has observed an increase in demand due to the recommencement of patients whose treatment had been deferred on a clinically managed basis in response to the Covid pandemic. This group of patients will have initial treatment durations of 3-4 months and associated impact on our demand/capacity. Again a process is in place for clinical prioritisation and is being overseen by the clinical lead for SACT and VCC Clinical Director.

252 non-emergency new patients began treatment in month. Of these 141 of these patients breached due to capacity issues. There were 4 emergency patients in month and 2 breached the 5 day target.

Since the September report the longest wait has reduced from 49 to 31 days and as a result of ring fencing emergency chair capacity, we have eliminated emergency breaches. In response to the challenge of providing sufficient capacity in response to the Covid 19 impact on the service delivery, a number of innovations have been introduced. There has been an increase in the delivery of oral SACT and Medicines at Home (270 extra per month as compared to pre-Covid levels), simple procedures performed in Outpatients have been increased by a 120 per month (from an historical norm of approximately 60 per month), extended capacity has been made available at VCC for SACT delivery and the workforce plan has been re-aligned. Active engagement with health boards is continuing with a view to securing extra capacity for SACT delivery in outreach settings by reinstatement of pre Covid clinics. It is important to acknowledge that health boards are also currently operating subject to severe constraints. Both Prince Charles and Neville Hall hospitals have plans now in place to return to previous outreach levels locally, which will impact fully in quarter 4.

Health board pharmacy services are now providing previous outreach levels to patients treated at VCC in advance of outreach returning. As a result of that and the additional VCC nursing input from inpatient care, it is envisioned that available SACT capacity will return to pre-Covid levels in November 2020.

We are continuing to work with Welsh Government and Local Health Board colleagues in modelling the system demand anticipated for the forthcoming months.

2.2.3 Velindre Acquired Potentially Avoidable Pressure Ulcers

There was 1 pressure ulcer classified as avoidable as there was a lack of evidence to demonstrate regular checks or attempts made to relieve the pressure. Learning has been identified, and cascaded to the nursing team in order to reduce the risk of reoccurrence. This will continue to be monitored.

2.2.4 Velindre Acquired Healthcare Associated Infections

There was 1 C. Difficile infection deemed to be Velindre acquired in September. The patient was nursed in a cubicle throughout the stay and the case is not linked by genomics to any other case.

Completed RCA reviewed by IPCT and Consultant microbiologist end of October to identify if any lessons could be learned. Awaiting outcome.

2.2.5 % of newly presenting patients who receive a diagnosis of sepsis and receive all 6 elements of treatment in 1 hour.

9 patients triggered for sepsis and met the triple trigger criteria, 2 of these breached the 1 hour sepsis target due to a delay in medical assessment. One was due to a delay in patient review in outpatients and one was a delay in antibiotic administration. Both cases have been reviewed, assessed for feedback and learning and there was no harm from the delay.

Of the 9 patients, 2 had a sepsis diagnosis. Both patients with a sepsis diagnosis were administered the sepsis bundle within 1 hour.

2.2.6 % of patients who rate patient experience as 9 or above

68% reported against a target of 80%.

Patients returning lower scores in September in relation to their experience of treatment at VCC commented on several themes, including:

- Social distancing in the Outpatient Department
- Waiting times for bloods
- Compassionate communication

All of these issues have been fed into the operational teams for action and SMT will be monitoring these parameters. For Phlebotomy, plans are in progress for relocation of the service from outpatients to improve access and flow.

3. KEY DISCUSSIONS ARISING FROM VELINDRE CANCER CENTRE (VCC) QUALITY and Safety MANAGEMENT GROUP (QSMG)

3.1 The VCC QSMG is a multidisciplinary team of representative managers and employees whose roles are directly concerned with establishing, developing and implementing clinical governance within the service. It focuses on driving the implementation of improvements and safeguards in quality and safety. It is accountable to the Senior Management Team (SMT).

3.2 During its meeting in September the following areas were discussed in detail;

Issue	Action	Lead	Timescale
Reduction in patient experience scores in particular the key areas of feedback relating to communication of appointments,	<ul style="list-style-type: none"> Task and Finish Group to be established to map current appointment communication mechanisms, review process and content to make improvements to support the changes for virtual clinics etc. 	Head of IM&T	31 st December 2020
Reduction in numbers of patients, carers and visitors completing the feedback survey	<ul style="list-style-type: none"> Director of Operations and Patient Experience Manager to review current mechanisms, develop proposal to increase departmental ownership of survey completion. Awaiting Once for Wales Datix Module to allow more robust monitoring of activities 	Director of Operations	30 th November 2020
Draft Patient Falls Policy – to ensure roles and responsibilities are clear and that the pathway for VCC and outreach clinics is articulated	<ul style="list-style-type: none"> Comments provided with view to approving policy at November meeting 	Deputy Head of Nursing	30 th November 2020
Lack of access to manual handling training due to the pausing of Service Level Agreement (SLA) by Cardiff and Vale University Health Board (CVUHB)	<ul style="list-style-type: none"> Options paper to be developed 	Trust Education and Development Manager	30 th November 2020

4. HOW SAFE IS OUR SERVICE?

Incidents

4.1 There 177 incidents reported in the month of September 2020.

4.2 160 were categorised as no harm, 11 low harm and 6 moderate harm. There were no severe incidents in September 2020.

No harm

No harm (impact not prevented) - Any incident that ran to completion but no harm occurred to people receiving NHS funded care

Low

Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care

Moderate

Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care

Severe

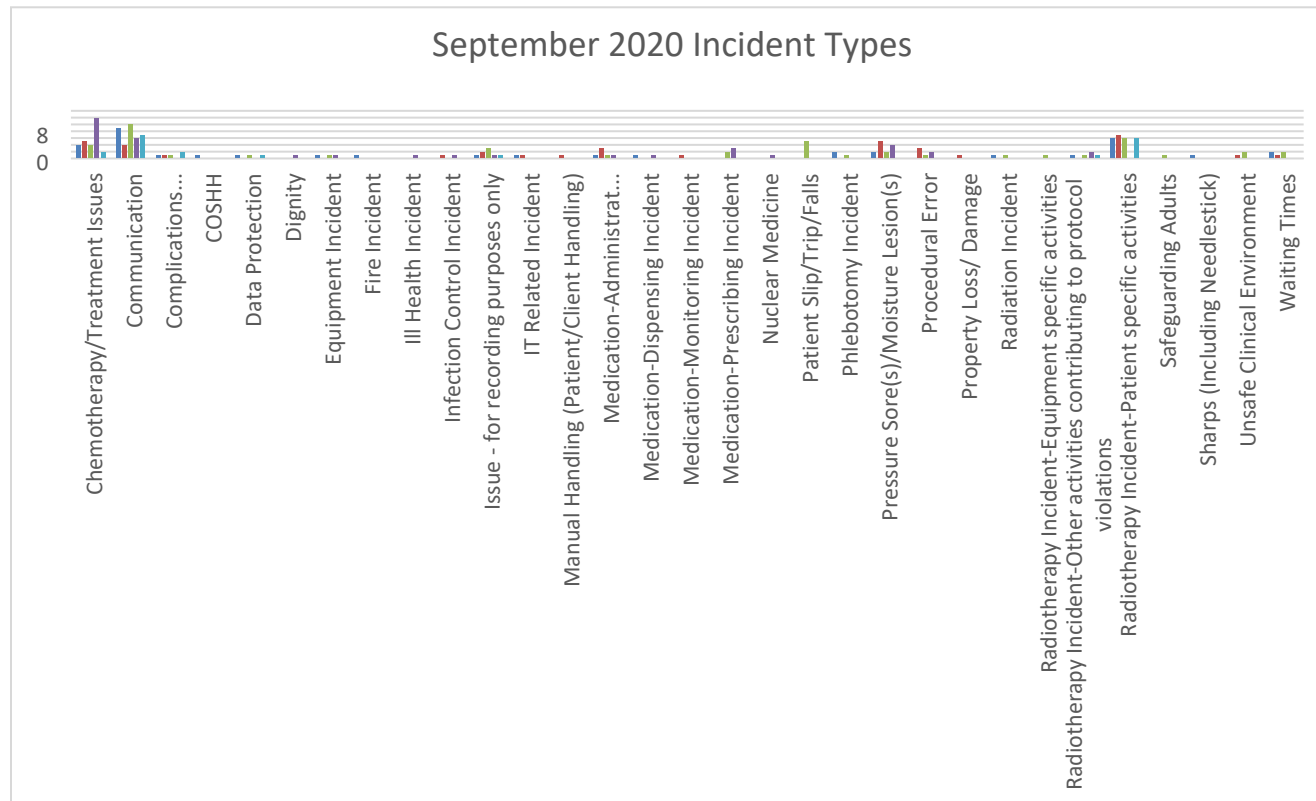
Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons

Death

Any unexpected or unintended incident that directly resulted in the death of one or more persons

4.3 Graphical analysis of incident type is shown below.

4.4 Further work will take place during October/November to provide a more triangulated approach to report information.



4.5 Serious Incidents (SI's) There were 3 serious incidents reported to Welsh Government in this reporting period Incident 1 has been completed whilst incident 2 and 3 are still under investigation and will be reported at a future meeting. Details are as below;

Incident 1: Related to delivery of chemo-radiotherapy. And was and was also reported as an Ionising Radiation (Medical Exposure Regulations IR(ME)R incident to Health Inspectorate Wales (HIW). The root cause was found to be human error however 4 issues were found to have contributed to the error. A full action plan is being developed and will be delivered. Lessons learnt are being disseminated.

Incident 2 (under investigation): At the end of an Outpatient clinic, it was noted that a pack of FP10 and IP10 prescription pads for community use and a pack of 'Fitness to work' certificates were missing. The prescription pads had been pre-stamped with the Velindre Hospital's official stamp. This incident was initially reported as a no surprises incident and upgraded by Welsh Government (WG).

Incident 3 (under investigation): An alert was raised on discovery of a clinical correspondence discrepancy in which 256 letters that had been drafted for individual patients had not been issued and were being held in Document Management System for over 90 days. A number of these had been on the system for 20 months. These letters included those with instruction to other clinicians as onward referral, instruction to General Practitioner (GP) and information sharing with GPs. This incident was initially reported as a no surprises incident and upgraded by Welsh Government. The first stage of the investigation has identified no adverse patient impact from the issue. The investigation also includes a full mapping of the correspondence generation pathway which is being reviewed.

4.6 IRMER Compliance/Issues/Incidents

*Radiation incident (RI) refers to an error in the delivery of radiation during a course of radiotherapy which could have resulted in unnecessary harm. They are classified as follows;

- Reportable (under IR(ME)R or IRR)- will generally be clinically significant but may be correctable
- Non-reportable - of potential or actual clinical significance
- Minor – of no potential or actual clinical significance

During September 2020 only 6 minor incidents were reported. These included transcription errors, positioning errors and accessing in incorrect form. A full review of each has been undertaken with appropriate patient engagement. Feedback has been provided to each staff member involved, role competencies have been revised and procedures reinforced.

4.7 No safeguarding incidents involving care a VCC.

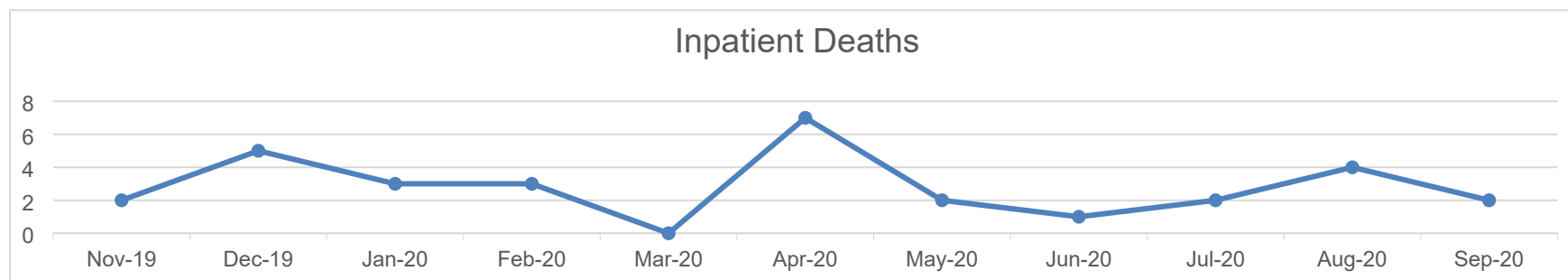
4.8 VCC staff identified and reported safeguarding concerns to the local authority, in line with the Wales safeguarding procedures.

4.9 **Mortality Reviews** continue to be undertaken on all VCC inpatient deaths in line with WG guidance and Medical Examiner Regulations.

4.10 There are no trends or concerns.

Number of Inpatient Deaths:

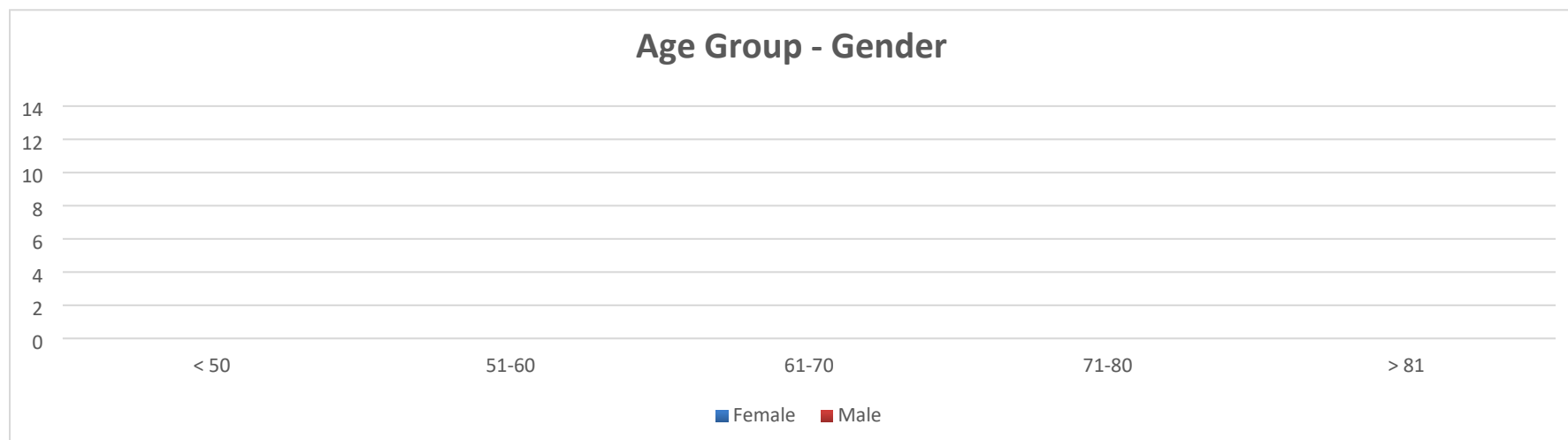
Month	Number of deaths
Nov-19	2
Dec-19	5
Jan-20	3
Feb-20	3
Mar-20	0
Apr-20	7
May-20	2
June-20	1
July-20	2
Aug-20	4
Sept-20	2



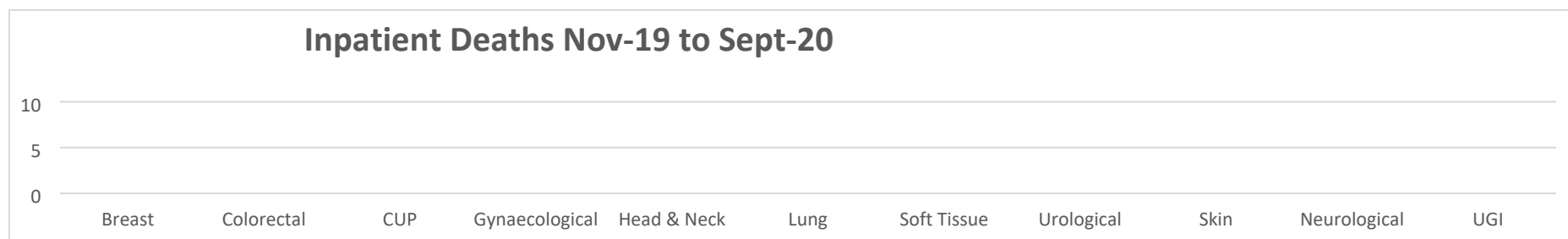
Cause of Death:

Cause of Death	Number of patients
Malignant disease	12
Covid-19, Malignant disease	5
Amyloidosis/Bladder Cancer	1
Bowel obstruction Adenocarcinoma sigmoid colon	1
Covid-19 & MI COPD	1
Hospital acquired pneumonia/Metastatic Ovarian Cancer/Parkinson's Disease/Severe Kynosis and frailty	1
Pneumonia, Pseudo Bowel Obstruction, Metastatic Prostate Cancer	1
Metastatic disease	7
Bronchial Pneumonia	1
Pneumonia, Glioblastoma	1

Patient Demographics:



Breakdown by SST:



4.8 Clinical Audit plan update

4.8.1 Please see Clinical Audit Highlight Report that is under a separate agenda item.

4.9 Healthcare Acquired Pressure Ulcers

The monthly VCC scrutiny panel continues to meet to review all reported pressure ulcers and to capture learning/follow up actions. The TVN temporary post is demonstrating value in leading each review and remedial actions to support improvement. There was 1 Velindre acquired pressure ulcer in September 2020 which has been detailed in previous sections.

4.10 Healthcare Acquired Infections

4.10.1 There has been no infections related to **urinary catheters** in Q2. IPCT have worked with staff to improve maintenance bundle compliance. There has subsequently been an improvement in Q2.

4.10.2 Hand Hygiene Compliance

4.10.2.1 Compliance has been variable across departments and staff groups in Q2 with overall compliance across departments at 95%.

4.10.2.2 The radiotherapy department compliance is shown as 70% and this will be addressed with the team as part of the formal performance meetings.

4.10.2.2 The data reported is from snap shot audits undertaken by Hand Hygiene Champions that work across departments. They observe a minimum of twenty hand hygiene opportunities of any staff group within their department. IPCT collate the information and provide the analysis. The audit process has been reviewed to ensure the Champions audit more opportunities from individual staff groups as compliance is affected significantly when low numbers are observed.

4.10.2.3 The IPCT will be working with the Champions to set up a hand hygiene training programme for staff. It is envisaged that the Champions will deliver the training within their departments with support from IPCT.

4.11 Responding to Sick Patient / Sepsis

4.11.1 Sepsis data is captured and submitted every month any non-compliance is investigated and reasons are reported through the VCC performance framework. In September 2020 9 patients triggered for sepsis and met the triple trigger criteria 2 out of these breached the 1 hour sepsis target both breaches were related to delayed medical review no harm to either patient.

4.12 Do Not Attempt Cardiopulmonary Resuscitation (DNARCPR)

4.12.1 The Wales DNARCPR standard is subject to a 2 yearly audit of completed forms that assesses document completion, the process of completion (who, when, why and how), the appropriate consideration of capacity, patient and family involvement. The All Wales mortality review captures data on compliance with the completion and timeliness of DNARCPR processes.

4.12.2 The associated End of Life Care results and action plan were discussed at the July and August 2020 meetings.

4.12.3 The Inpatient Strategic Group actively monitors the actions and provide updates via Highlight Reports to the VCC SMT.

4.12.4 Below the current status of the actions. All have been closed.

Recommendations	Update September 2020
Velindre SPCT to continue teaching CDG in Doctors induction and training Student nurse teaching Ward staff updates	Actioned and closed
Together with Velindre education and development department promote the use of the All Wales CDG Module on ESR while awaiting the updated version (delayed due to C19). To become part of induction and PADR/Core training	Actioned and Closed ESR module promoted and available
Ward link nurses/outpatient department - plans to implement a ward link nurse scheme has been delayed by C19 and ward/staff changes. This will be relaunched with relevant staff receiving additional training and supervision with SPCT to empower and facilitate their role as link nurses	Tutorial groups from wards and OPD have been offered. Challenges due to C19, other competing priorities and high level of 'champions/link nurses' required
Velindre SPC nursing steam to provide a service 35 days per year. With the extended hours of the assessment unit and increased acuity of patients the team are working towards having a member of team on site from 8am-8pm whenever possible.	Actioned and closed. Additional resource approved and currently under recruitment.

4.13 Patient Falls

The VCC Falls Policy will be approved at the November 2020 VCC Q&S Management Group, a falls scrutiny panel has been established and held its first meeting October 2020. There were 3 Patient falls in September with the narrative shown in PMF

4.14 Deprivation of Liberty Standards (DoLs) Compliance

VCC is a managing authority. 1 urgent application was submitted to the supervisory body in September and withdrawn prior to assessment.

5.0 Covid-19

5.1 Clinical Principles

In response to lessons learnt from 'wave 1' of the pandemic and in response to the Welsh Government's ambition to continue essential service activity during the pandemic, VCC's principles, plans and pathways are being reviewed in light of this with an aim to remain a Covid "Green" site. Discussions are underway with LHBs to agree patient admission criteria to facilitate this.

5.1.1 Maintaining this status requires active plans for site utilization and access, staff management and patient testing plans.

5.1.2 There are robust clinical management and pathway plans in place for Inpatients, SACT, Radiotherapy and Outpatients as the key service areas. These are reaching the final stages of approval via the Site Specialist Teams (SST's).

- 5.1.3 VCC have formally assessed its plans, processes, pathways and lessons from incidents/outbreaks against the 15 Principles developed as a result of the outbreak at Cwm Taf University Health Board which have been shared across NHS Wales. This will be presented to the SMT in November.
- 5.1.4 As reported in August 2020, VCC managed a staff Covid-19 transmission incident during August – September 2020.
- 5.1.5 A number of improvement actions were required of the Cancer Centre as a result of this and identified following a number of infection control walk arounds the Cancer Centre. One overarching action plan was been developed covering all required actions which has now been closed, with the exception of ongoing actions around COVID precaution principles.
- 5.1.6 A follow up peer review visit by the Senior Nurse at Public Health Wales (PHW) is planned for 13th October 2020.
- 5.1.7 An assertive approach to symptomatic staff was taken even if a negative result was obtained.
- 5.1.8 There was no patient impact or impact on clinical services.
- 5.1.9 All staff have now returned to work.
- 5.2 **Personal Protective Equipment (PPE)**
 - 5.2.1 A formal monitoring process has been put in place to monitor fit testing and donning and doffing compliance.
 - 5.2.2 There is also a dynamic model that is updated daily to reflect availability of PPE.
 - 5.2.3 All fit testing and donning and doffing competencies have been added to the individual's Electronic Staff Record (ESR) which is a significant step in managing future changes etc.

5.2.4 As at the end of September, 87% of staff who require a mask for their duties have been fit tested and 76% have completed their donning and doffing training. Managers are required to ensure full compliance within their areas and this is monitored by the Trust PPE Cell.

5.3 Social Distancing

5.3.1 Welsh Government published Covid-19 guidance for employers and businesses on the 6th March 2020, and updated this on the 18th May 2020.

5.3.2 All departmental managers have completed formal risk assessments for each of their areas. In view of the second wave and some evidence of possible staff to staff transmission these are currently being reviewed and amended where necessary.

5.3.3 The accommodation plan to meet the above requirements has been partly enacted which has allowed the service to meet the needs of the medical teams, the medical staff mess requirements, COVID patient testing team, SACT booking team, clinical nurse specialists (CNS), senior nurses and additional space for clinical handover.

5.3.4 Phase 2 of this plan will now be refined to manage the outstanding requirements and unintended consequences of some of the above (ie operational services have been displaced to meet accommodation requirements of CNS's).

5.3.5 Areas of concern that remain relate to changing facilities, reduction in dining room/break out space and the outstanding additional office space required for phase 2 whilst managing an already overcrowded site.

5.3.6 Social Space for Staff

A number of options have been considered particularly given the move into the winter months which leads to external space being inappropriate. The requirement to meet core service needs as detailed in 5.3.3 above, has led to a number of meeting rooms being repurposed. Again, this further limits the options available on the site which is severely restricted. It has also meant that any face to face training required has been moved off site.

- As of Thursday 29th October 2020 the Transforming Cancer Services (TCS) meeting rooms will be utilised for staff break purposes..

- Perspex screens are being reviewed by the IPC team to use within the dining room which would increase the seating from 25 to 50.
- The possibility of an online space booking process is being considered.
- All staff breaks have been mapped in order to assess the spread across the services to identify peak times, flow etc.

5.3.5.2 Changing Facilities

Although this is being actively managed, this continues to be a major challenge for VCC in view of its space restrictions. A full mapping exercise of demand has been undertaken and an options paper to alleviate some of the pressure will be developed for the SMT to consider. A recent infection control audit has highlighted areas for improvements, where possible immediate issues will be addressed and a business case developed.

6.0 HOW EFFECTIVE and EFFICIENT IS OUR SERVICE

6.1 **Healthcare Standards (HCS)** Compliance against the action plan is discussed monthly at the VCC SMT. A total of 31 actions were included with 6 relating to Trust wide Infection Control actions.

6.1.1 Two have been carried over from previous year's actions – Systemic Anticancer Therapies (SACT) algorithms and Patient Reported Outcome Measures (PROM's) Patient Reported Experience Measures (PREM's). Both are now making positive progress and are on schedule to meet the revised timescale.

6.1.2 The table below outlines the achievement status and full action plans are shown below.

No	RAG		CHANGE
18	GREEN	On Target	=
10	AMBER	On Target for completion within timescale (12 months)	1↑
3	RED	Unlikely to be achieved within year	1↓

6.1.3 The 3 red outstanding actions are detailed below.

- Two due to external factors – the one has been escalated appropriately
- One is relating to the Welsh Language Standards compliance – currently there is no resolution but will be discussed with the Welsh Language Officer and Head of Communications. This has been delayed due to the resources required to manage the nVCC planning permission communications.

6.2 **Site Specialist Team (SST) Annual Report Appraisals**

A key element of monitoring, discussing and engaging with clinical teams is the annual report appraisal meetings. The framework for these is shown in **appendix 2**. The key areas of reporting and discussion include;

- Workforce planning
- Staff Survey
- Achievements
- Challenges
- Activity
- Death within 30 days
- Aspirations
- Integrated Medium Term Plan (IMTP) pocket plans
- Research and Academic activities

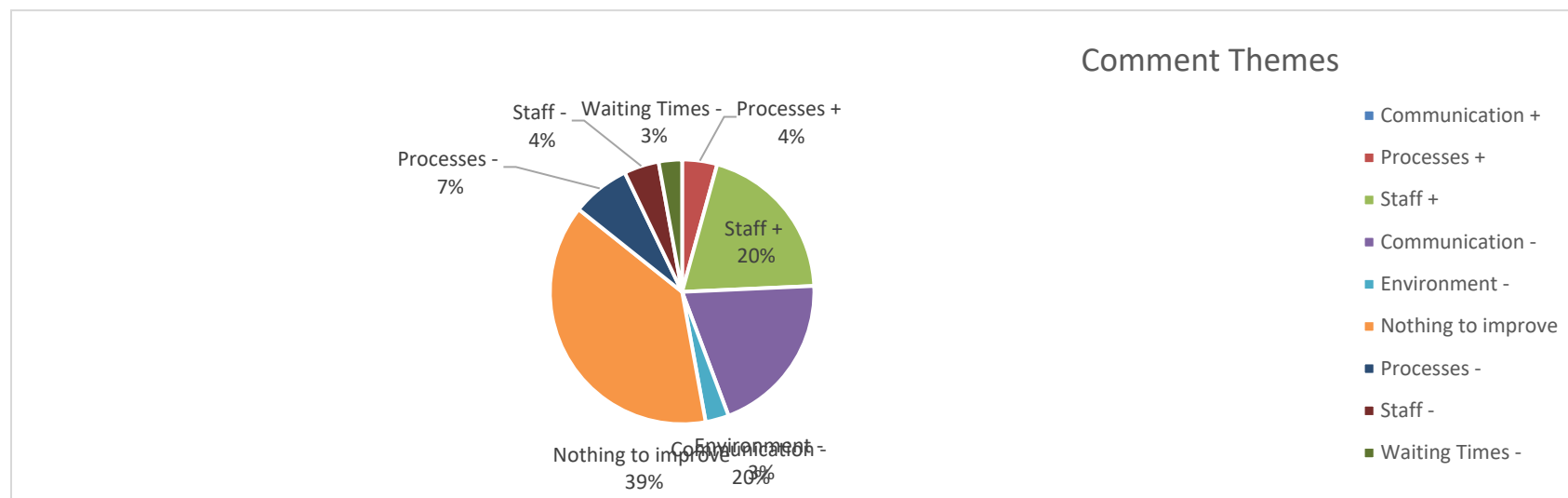
A summary of future reports will be included within the report with the full detail included as an appendix 4. During October the Lung, Head and Neck and Neurological teams are due to present their reports.

7.0 **WHAT OUR PATIENTS ARE SAYING**

7.1 **Survey Summary**

- Total of **78** online surveys completed (32 full surveys, 3 snapshot surveys, 43 Virtual Consultation surveys)

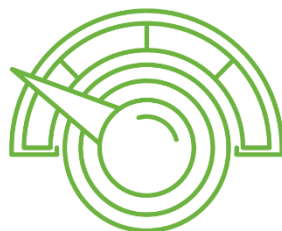
- Overall experience: **68% of patients** (50/73) rated their experience as excellent (9 or above)
- The highest score was **10** (36) and the lowest score was **0** (3)
- There were no contact details provided for those that provided 0 scores
- Where details are provided contact is made with the respondents
- **106** total comments



- 58% (18/31) felt they were always listened to
- 61% (19/31) felt the time they waited was about right
- 61% (19/31) felt things were always explained in a way they could understand

Understanding Our Lower Scores

(8 and below)



3 people rated 0/10	<ul style="list-style-type: none"> • Not keeping phone appointments. Staff need more training to deal with patients. • Consultant attitude. • Never listened to or cared for, first floor ward.
1 person rated 1/10	<ul style="list-style-type: none"> • Outpatient bloods incident.
1 person rated 3/10	<ul style="list-style-type: none"> • Never assisted when needed. Melanoma.
1 person rated 5/10	<ul style="list-style-type: none"> • Chaotic outpatients.
3 people rated 6/10	<ul style="list-style-type: none"> • GP communication / long distance travel • 3 hour wait • Prefer face to face consultation
6 people rated 7/10	<ul style="list-style-type: none"> • Lack of contact • Radiotherapy experience • Unhappy with virtual appointment • Lack of connected communication, ambulance arrived unwanted, standards dropped since COVID • Iron low and needed infusions • No comments
8 people rated 8/10	<ul style="list-style-type: none"> • Waiting times, lack of continuity • No comments, Tenovus Unit • Prefer face to face appointments • Harder to explain symptoms over the telephone • Would prefer video call to telephone • Nothing to improve

- | | |
|--|--|
| | <ul style="list-style-type: none">• Prefer face to face appointments• No comments |
|--|--|



Dept	Surveys	Lowest Rating	Highest Rating	To celebrate	To improve
Outpatients	12	1	10	<ul style="list-style-type: none"> Support from Dr Powell and Dr Hannah Hardworking HCSW staff Exceptional staff 	<ul style="list-style-type: none"> Phlebotomy experience More contact needed during COVID GP communication Long distance travel
Inpatients	3	0	10	<ul style="list-style-type: none"> Fab nurses 	<ul style="list-style-type: none"> Didn't feel cared for Didn't feel listened to
SACT	6	9	10	<ul style="list-style-type: none"> Support from Oncology Nurse Excellent care in the day unit 	<ul style="list-style-type: none"> Better provision to rearrange treatment that has been cancelled because of blood test results
Radiotherapy	8	0	10	<ul style="list-style-type: none"> Excellent care & dignity Short waiting times Amazing staff 	<ul style="list-style-type: none"> Difficult to hear and lip read staff in PPE Check-in experience when patient running late Consultant attitude
Clinical Trials Unit	1		10	<ul style="list-style-type: none"> Always listened to and acknowledged by every member of staff. I feel like Velindre is my second family. Care is outstanding and second to none. 	<ul style="list-style-type: none"> A chocolate cake on arrival maybe? 😊
Other: Melanoma Urology	2		3 0		<ul style="list-style-type: none"> More staff training required Keeping phone appointments



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Compliments



I have today finished a 20 session course of radiotherapy treatment for Prostate Cancer. The treatment took place in LA4 at Velindre.

I should like to commend all the staff within LA4 for their supportive and professional manner.

It has obviously been a worrying time for me and my family, the positive attitude of the staff and interest in me have helped significantly.

Your organisation is a credit to NHS Wales.

- via PALS inbox (September 2020)

My dad asked me to pass on his eternal gratitude to you and your colleagues. I also want to thank you again for everything you have done for dad. The Marie Curie Home Towers Palliative care team visited Dad on Friday. It was excellent and I was part of the meeting which was extraordinary. I got back home last night and left dad in a much better condition, confident there is much more of a local safety net around him.

What fantastic work you all do.

I just wanted to say a huge thank you to you and the Velindre team.

The care and compassion I received from yourself and the whole team, throughout this very daunting time, has been incredible. From reception to the Chemo Nurses (who did make me laugh while having treatment!) are all amazing people.

Velindre truly is a very special place! Many thanks again and best wishes to you all

Profiad y Cleifion Patient Experience

Medi 2020

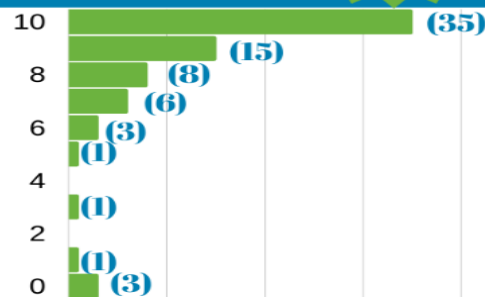


September 2020

o gleifion yn
gystyried eu
profiad fel bod
yn rhagorol
(9/10 neu
uwch)

Mae
68%

of patients
rated their
experience as
excellent
(9/10 or
above)



50 o sgoriau rhagorol
23 islaw sgoriau rhagorol

50 excellent ratings
23 below excellent ratings

Oeddech chi'n teimlo bod rhywun yn
gwrando arnoch?

58% Bob Amser **19%** Fel Arfer
10% Weithiau **13%** Byth

Did you feel that you were listened
to?

58% Always **19%** Usually
10% Sometimes **13%** Never

Oeddech chi yn medru siarad Cymraeg
â'r staff os oeddech yn dymuno
hynny?

3% Weithiau
97% Dim yn berthnasol

Were you able to speak to staff in
Welsh if you needed to?

3% Sometimes
97% Not Applicable

O'r adeg y cawsoch ddeall fod angen i chi
ddefnyddio'r gwasanaeth hwn, oeddech
chi'n teimlo fod rhaid i chi aros:

16% Llai na'r disgwyl
61% Tua'r disgwyl
16% Ychydig yn rhy hir
6% Llawer rhy hir

From the time you realised you
needed to use this service, was the
time you waited:

16% Shorter than expected
61% About right
16% A bit too long
6% Much too long

Oeddech chi'n teimlo bod rhywun
yn gofalu'n dda amdanoch?

61% Bob Amser **16%** Fel Arfer
10% Weithiau **13%** Byth

Did you feel well cared for?

61% Always **16%** Usually
10% Sometimes **13%** Never

Os wnaethoch chi ofyn am help, a
gawsoch chi help pan oedd angen?

55% Bob Amser **6%** Fel Arfer
13% Weithiau **6%** Byth
19% Dim yn berthnasol

If you asked for assistance, did you
get it when you needed it?

55% Always **6%** Usually
13% Sometimes **6%** Never
19% Not Applicable



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Oeddech chi'n deall yr hyn oedd
yn digwydd yn eich gofal a'ch
triniaeth?



Did you feel you understood
what was happening in your
care? **48%** Always

48% Bob Amser **32%** Fel Arfer **32%** Usually **10%** Sometimes
10% Weithiau **10%** Byth **10%** Never

A gafodd pethau eu hesbonio
wrthyg chi mewn modd y
gallech ei ddeall?



Were things explained to you in a
way that you could understand?

61% Bob Amser **23%** Fel Arfer **61%** Always **23%** Usually
10% Weithiau **6%** Byth **10%** Sometimes **6%** Never

A gawsoch gyfle i gymryd rhan
yn y penderfyniadau am eich
gofal, yn ôl eich dymuniad?



Were you involved as much as
you wanted to be in decisions
about your care?

61% Bob Amser **19%** Fel Arfer **61%** Always **19%** Usually
13% Weithiau **6%** Byth **13%** Sometimes **6%** Never

Arhosais 3 awr am
apwyntiad 20 munud. Ni
fyddaf yn gallu gwneud
hynny eto. Blinedig dros ben.

I waited 3 hours for 20
min appointment.
Cannot do that again.
Exhausting.

Was there
anything that
we could
change to
improve your
experience?

Oedd yna
unrhyw beth y
gallwn ei
newid i wella
eich profiad?

Anodd clywed a darllen gwefusau
staff sydd yn gwisgo Cyfarpar
Diogelu Personol

Difficult to hear and lip
read staff in PPE

A oedd unrhyw
beth neilltuo o
dda am eich
profiad yr
hoffech ei
rannu gyda ni?



Was there
anything
particularly good
about your
experience that
you would like to
tell us about?

Mae pob aelod o staff yn
gwrando arnaf bob amser, ac yn
fy nghydnabod. Rwy'n teimlo mai
Felindre yw fy ail deulu. Mae eich
gofal yn rhagorol, a heb ei debyg.

I'm always listened to and
acknowledged by every member
of staff. I feel like Velindre is
my second family. Your care is
outstanding and second to none.

Roedd y tîm radioleg yn
wych, a gydag agwedd
ofalgar iawn tuag ataf

The radiology team
were excellent and had
a very caring attitude
towards me

Velindre.PALS@wales.nhs.uk

Fe ddywedoch chi...
fe wnaethom ni...



You said...
We Did...



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The majority of **comments** received from patients this month (39%) highlight that there is nothing that could have improved their experience, however the lower scores do indicate that the impact of several changes to the service over recent months are contributing to an overall less positive experience for patients.

✔ **Medicine Collection Point**

Our Operational team have worked closely with pharmacy to introduce a dedicated Medicine Collection Point for patients. The parking spaces are near the pharmacy entrance, clearly marked and allow for reduced footfall within the department as well as a simple and straightforward collection service for patients.



✔ **Transparent Face Masks**

Some patients have commented how difficult it is to hear and lip read staff wearing PPE face masks. We are currently testing use of transparent face masks in some areas to assess if this would be a suitable solution.

✔ **Outpatients Outdoor Waiting Shelter**

We have made arrangements for a temporary shelter to be fitted which will have suitable lighting and heating as well as enough space to comply with social distancing guidance. A permanent solution is still being explored, however we were keen to avoid any further delays which would impact our patients during the cold and wet weather.

Additional Surveys



Virtual consultations at
Velindre Cancer Centre

- 7.2 As COVID has led to an increase in the use of **virtual consultations** a team have been asking patients about their experience of virtual consultations recognising that this is a huge change in the way that some of our services are delivered. Therefore it is important to understand the impact this is having on their overall patient experience.
- 7.2.1 Largely, the responses are positive however the importance of individual choice and patient preferences need to be considered as well as keeping our patients safe.
- 7.2.2 43 responses were received.
- 7.2.3 90% of these received their consultation via telephone and 10% via video call. 97% stated the audio/video quality was above good and the majority (72%) used a smart phone. The reason for the consultation were varied to include discussions around results, discussing treatment options, follow up appointments and introduction sessions.
- 7.2.4 Feedback has been positive and has will be presented to the relevant VCC groups.
- 7.2.5 The OPD Programme Board continue to monitor the levels of virtual versus face to face consultations.

		Clinic type group	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Total
Total Virtual Appointment - Video	Virtual	All	877	1412	2740	2614	2165	2507	12315
Total Telephone	Telephone	All	453	401	565	487	401	466	2773
Total Face to Face Appointment	Face to Face	All	3000	2278	1694	2233	2173	2485	13863
Grand Total	Grand Total		4330	4091	4999	5334	4739	5458	28951

7.3 Complaints/Concerns/Claims/Compliments

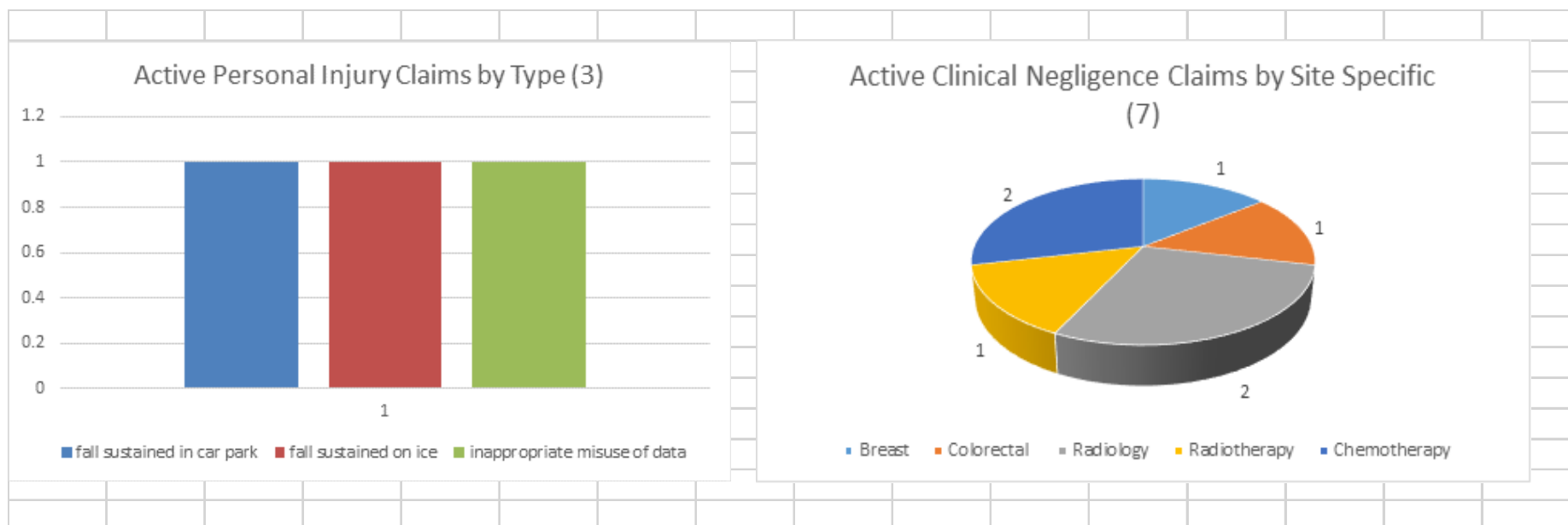
Type of concern	No.	KPI Achieved
Early resolution	14	100%
Putting Things Right (PTR) (formal concern)	6	100%
Claims	0	NA

7.3.1 A summary of the key themes is highlighted below. Improvement plans and lessons are captured and demonstrated in previous content ie sections 3 and 7.

7.3.2 There are no identifiable trends but there has been an increase in the numbers compared to previous months. This is due in part to the formal recording of early resolution complaints onto the Datix system which allows more robust data capture.

Formal concerns	Early Resolutions
Clinical Treatment / Assessment (decision to stop treatment) Clinical Treatment / Assessment (Delays in receiving treatment) Discharge issues (unhappy with discharge plan) Attitude of staff member	Lack of communication (appointments / bloods) Appointments (waiting times) Transport Times

7.3.3 There are 7 ongoing medical negligence and 3 personal injury claims. There were no new claims, or claims that have been closed during September 2020.



7.3.4 Compliments

Unfortunately there is no robust system within VCC to capture and report compliment data. Huge amounts of compliments are received in the form of letters, cards, chocolates, via social media, verbally etc. Where possible departments do keep a manual, paper based log of simple data such as numbers received. It is hoped that the Once for Wales recording system will allow electronic capture therefore providing a more robust solution.

7.4 Patient Engagement Update

Acute Oncology Service - Focus Group Sessions

- 7.4.1 The purpose of the online focus groups was to capture patient and carer views and values on key principles related to the development of the acute oncology service.
- 7.4.2 Two sessions were held in late August 2020 and involved 8 participants, including patients and carers. In addition to the discussions, 10 participants completed an anonymous online poll.
- 7.4.3 **Participation** A short video was produced to explain the definition of Acute Oncology and was included as part of the session invitation <https://youtu.be/VIL8ut-ChCw>. Participant recruitment was also supported by health board patient experience leads.
- 7.4. The discussions centred around four key themes a summary of which is as below. The full comments under each theme are detailed in appendix 3.

8.0 WHAT OUR STAFF ARE SAYING

Health and Wellbeing Survey Results

- 8.1 The Trust has undertaken a specific survey regarding the health and wellbeing of staff during and following 'wave 1' of the COVID 19 Pandemic.
- 8.2 The results and key themes will be discussed at a future EMB resulting in the development of an action plan.
- 8.3 Compliance with the workforce key indicators are shown in appendix 1.
- 8.4 Below is a summary of the key issues;

8.4.1 Performance Appraisal and Development Review (PADR)

Small increase in figure from that reported last month (69.42 September and 65.85% August). All Department managers being asked to provide an improvement plan which will be monitored by SMT, and any Departmental Performance Review meetings that are held. Improvement plans due within the next week, with compliance rates to be reviewed at November's SMT where an improvement is expected.

Managers to be reminded that a PADR is required at least annually, and that in the current climate it may be more appropriate for shorter term PADR's that are reviewed more frequently. This should help clarify the expectation that PADR's continue where possible, and also help demystify any conception that PADRs are an annual conversation only.

Medical staffing PADRs are recorded via a separate system called MARS. 62 Consultants on a Medical Appraisal Revalidation System (MARS) (including Palliative Medicine and Welsh Blood) of which 53 have appraisals that are in date (including 20 which have been deferred between 1 /4 and 30/9) – taking them to 82% compliance. Recruitment of a Revalidation Support Officer will ensure this data is transferred to ESR.

8.4.2 Training Compliance

There has been a very small decrease but fairly static around 78%. Education and Development to support medical workforce in terms of scoping out anticipated time for Core Standards Training Framework (CSTF) to be completed for this to be mapped into job plans.

8.4.3 Fire Safety

- The Trust have a target of a minimum of 85% for compliance in fire safety training.
- The National Core Training Skills Framework categorises the requirements in 2 levels.
 - Level 1 is via e-learning, biannually and aimed at non clinical staff.
 - Level 2 is an annual course aimed at clinical/patient facing staff.

- The level of compliance within VCC as at 21st September 2020 is below this target at 29% (as at 25th September 2020) for level 2 and 75% for level 1. This a slight increase of the level 2 training of 4%. At the time of writing this report, there has also been significant increase during October 2020 which will be reported at a future meeting.
- The SMT have received plans for all poor performing departments and the will be actively monitored via fortnightly SMT performance meetings, individual meetings and service level performance appraisals.
- The Fire Advisor and Education and Development Manager are actively pursuing alternative options for training provision as classroom sessions are limited due to COVID 19 social distancing etc. The emphasis is to provide practical education that was achieved via regular walk rounds combined with a classroom session.

8.4.3 Sickness

In month figure fairly static last few months but last 2 months seen steady increase in short term sickness absence, and decrease in long term sickness (LTS). Reasons for increase in short-term (ST) absence related to chest/respiratory and cough, cold, flu. Increase of Covid related absence from 0.36% in month sickness absence August to 1.3% in September. The Workforce and Organisational Development team (WOD) are completing a data quality check to ensure that the entries of absence for this reason are accurate and appropriate but correlates with reasons for absence and extended symptom list in operation.

8.4.5 Annual Leave

This continues to be monitored. Acknowledge that the figures may slightly under represent what has actually been booked as Radiotherapy have only just started using ESR to record annual leave consistently, with a phased roll out across the Department over the next 6 months. In addition the WOD team are supporting Operational services to use ESR for this purpose as there are ongoing issues with consistent access to IT and also confidence in using the system.

9.0 WHAT OUR REGULATORS / EXTERNAL / INTERNAL ADUIT ARE SAYING

- 9.1 There have been no internal audits during the period or outstanding actions.
- 9.2 There have been no external audits, inspections or regulatory visits.

9.3 The external peer review undertaken following the COVID-19 outbreak in August-September 2020 has been documented in a previous section.

9.4 The delivery of the improvement actions as a result of the Health Inspectorate Wales (HIW) IRMeR visit in November 2019 is continuing with the majority of actions being achieved. A more detailed update will be available in November 2020.

10.0 RISKS

10.1 The VCC Risk Register is reviewed monthly with additional, updated or closed risks noted and discussed. However, SMT have recognised a need to improve the risk register and actions are now in progress to remedy shortcomings. These include all departments will be contacted by Quality and Safety manager to review all current risk for quality of narrative and supporting mitigating actions. This will be followed up by a subsequent review by the Q&S and by the SMT lead.

11.0 ASSURANCE / LEARNING

11.1 There are no closed claims.

11.2 Learning and actions relating to incidents, complaints and patient experience is covered in the relevant section.

12.0 SERVICE DEVELOPMENTS / IMPROVEMENTS

12.1 Work is underway to develop a central Programme Management Office (PMO) and develop a Change Management Structure that will support clinical and operational services to deliver service change to achieve Organisational objectives. The PMO will work in close collaboration with the wider Senior Management, Operational and Clinical Teams to ensure work programmes are aligned to the VCC' strategic aims, and will support in delivering a number of key projects which will transform services, improve efficiency and deliver benefits for service users and patients.

13.0 **CELEBRATION and EXCEPTION**

13.1. **Celebration**

- Helen Way nominated to join St Christopher's, Community of Practice
- Alex Worgan, Healthcare Support Worker was shortlisted for the Royal College of Nursing award
- Fundraising Ambassador Tracey Davies aware British Empire Medal (BEM)

14.0 **CONCLUSIONS**

- Cancer services have been disrupted as a result of COVID-19 but VCC has maintained essential service delivery.
- A comprehensive review of those services was undertaken to ensure that the identified service transformations implemented in response to COVID-19 which should be maintained are aligned with our pre-COVID-19 service development plans and strategic intent.
- Some key performance indicators have not been met due to the above. Improvement plans are in place which will be reported against in the next report.



Appendix 3 – Results and Comments from Patient Engagement regarding Acute Oncology Service

Staying Well at Home

Our first theme focused on staying well at home and what kind of support would be helpful to enable this. All participants agreed that this is something they value hugely and that having the right information and verified advice is vital.

“Information about what I could do to stay well, and how the disease might affect that ability to stay well.”

I haven't yet needed such help, and do my best to stay reasonably fit and flexible, but if pain made it difficult for me to exercise I would value expert help to keep myself moving.

From a carers perspective it would be really helpful if there was a place (on the website or a booklet) where I could go and check some of the information. For example Mum told me that she wasn't allowed to eat fresh fruit and veg during chemo. I just had to accept this information but it would have been really helpful if I could have validated it and also understood the reasons behind it.

Following my breast cancer surgery I undertook physiotherapy at home in the form of short daily exercise routines via a patient workout DVD prepared by Macmillan Cancer Support provided to me by Velindre. It significantly helped me to restore movement and function when I was affected by my illness. It also helped to reduce my risk of illness in the future, ie lymphedema.

Physiotherapy and anything else that could help, such as alternative therapies

Patients highlighted the importance of eating a healthy diet, taking regular exercise when feeling able to, maintaining a sense of control and enjoying things that take your mind off a cancer diagnosis. They also reflected on things which hadn't helped them to stay well, for example financial worries and lack of psychological support.

"The thing for me was the worry about money. Even though I work, I had six months fully paid, you know, cancer doesn't look at the time. I was so worried about going down into half pay."

“If I was worried about something...I have to admit, I did keep a lot to myself. I kind of put on a brave face because I had the children at home and I didn't have a partner to talk to about it. I talked to my sisters but you don't want to worry family. That's how I was. So a lot of it is kept inside...being able to have that access to talk to somebody just about how I was feeling. I needed that.”

One patient shared that they were offered advice to eat “whatever they wanted” which they felt was contrary to expected advice and instead used the internet to research foods that were considered “good to eat” during cancer treatment. Getting the right advice here would have been really helpful. Carers also commented on getting correct information to be able to support their loved ones to stay well at home.

“I think from my point of view as a carer, my sister had dementia. So for things to be done at home and surroundings that she was familiar with would have been and was very helpful.”

Support from GP services was varied and this was felt to be a really key relationship where good communication links are vital.

“I don't go and see my GP because I'm generally coping really well. If I do contact them, especially if it's not cancer related, they just almost say, ‘Oh, you don't need to worry about that. You've got lung cancer, that's the least of your worries.’ And I say, ‘yes but I want to keep as well for as long as I can’...they also don't seem to get updates. Is the onus on me to keep them updated on my cancer?”

“I had a different experience with my GP, I was in regular contact with them. And my GP almost became kind of like a therapist for me. I spoke to her with different problems during my chemotherapy and she came out to my house a couple of times, and when I was really ill. So we had a good relationship in the sense of she knew exactly what I was going through.”

Both groups were unanimously supportive of the idea of having an app to monitor and report symptoms and side effects from home and felt that this would be a really useful way to be more involved, help structure clinical conversations and enhance the relationship with their team.

“It could work a bit like a blog or a passport, so at two o'clock in the morning when the world is asleep, and your brain is racing into all directions or you're feeling unwell and you don't know whether to ring Velindre, you don't know whether to ring the out of hours GP you don't know whether to ring the local emergency hospital....there's something that just brings you back to a quietness of ‘right let's just get my passport back out, let's see what this tells us’”



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I think this would be a good way to keep on top of any new symptoms that have developed.

Absolutely. I would also like to have access electronically to my scan reports, blood results etc.

I would be comfortable however it's vitally important that the app is introduced correctly to me as a patient through 1:1 dialogue

No leaflet please

I already have a Fitbit that monitors information, so happy to have this if it helps me.

"My temperature appeared to take over the world of many people. So whether it was me or my wife, whether it was people at Velindre, everything was based on my temperature. So whether I felt unwell or not, if I spoke to somebody, the first thing they ask 'what's your temperature?' I had a basic thermometer that just went under the tongue, but I never believed it because when we went to the hospital, they seem to have this fandangle one that sticks in your ears...that was the determining factor as to whether I saw somebody or whether I got admitted, was on the back of what my temperature reading was. And I never trusted the one that I had because it was, you know, just basic from Boots. You need to trust that what you're using is accurate because you focus on it so much. Wearing something that is verified would really take the pressure off."



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*Once a day as standard,
but if the need arose, up
to 3 times a day.*

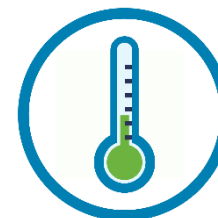
*It could be used as a diary /
blog to capture key information
for myself, my family*

*I think it's reasonable to input in
the morning and evening -
especially if it's quick to tap
"nothing to report"*

*Once a day but it would
be down to how unwell
I felt.*

Opinions varied on who should be able to access the information, depending on the relationship and what information would be available, with 20% choosing to keep access to personal use only. The conversation around digital exclusion and those who are unable or choose not to engage online also illustrated the importance of personalisation and choice when using digital tools.

"I think an app is a great idea and obviously it's going to suit probably 75% of people or perhaps more or less. However, I'm in my 70s and I think there will certainly be quite a lot of people who are really not into apps....There should be a choice, so there's an app, but there's also a hard copy version for those who prefer that."



Becoming Unwell

"I was so worried about getting ill during my chemotherapy, I was trying to do everything I could to prevent that from happening. And so I would take my temperature every day, for the week after I had chemotherapy and I keep an eye on it for the other two weeks for my next session. I would always make a note of my temperature and I would always make a note of new side effects that I was experiencing so then when I went for my blood tests, I would bring them up and say 'Is this normal?' ...any little pain in my head, as you can appreciate my mind would just go crazy."

The groups spoke about chemotherapy alert cards, contact numbers to call and most had used the services at some point, either for themselves or their loved ones. Some expressed confusion over which service to contact, whether out of hours GP, specialist cancer services or their local emergency department.

“Rightly or wrongly, I think I just automatically put Velindre at the top of the list...so if I think back I don't think I even thought about ringing the GP, I never thought about going to another hospital...it was Velindre or nobody. We rang them up and I live local so within 20 minutes I was walking onto the ward and being dealt with straightaway.”

I wouldn't speak to my GP. They do not understand or know enough about my situation in order for me to feel confident that they would be able to advise or treat me in the best way possible. I would wait to see my Oncologist.

I continue to be closely monitored by my breast care team & will continue to do so for the next 10 years. I have been provided with all relevant contact details should any new symptoms/problems arise. It really is fantastic aftercare.

Yes but I always felt I was being a nuisance. I think that more can be done to help encourage people to ask for help before it becomes serious

As a carer I would like to be given information on what to do in this situation.

The level of confidence to explain symptoms over the telephone ranged from 17% to 100% with an average of 77% with those scoring lower commenting that this was something their family member / carer / spouse would do for them as they felt so unwell. Reassurance and encouragement that contacting the team is the right thing to do is key to the level of confidence and patients spoke about not wishing to “waste anyone’s time” or “be a nuisance”.

I feel this question should also include "do you feel confident that the person you are speaking to understands your illness/systems"

Since the pandemic many consultants, hospitals have introduced virtual calls, appointments. I believe this should be the first option going forward unless its felt not suitable by the patient, for example if the patient isn't comfortable with this type of technology

Realistically, it can be hard to explain or you feel stupid or embarrassed...you are brave enough to make the call so don't want to feel a nuisance

I'd prefer to see someone, online would probably be fine.

Participants were geographically from all over the region, with some living very close to Cardiff and others around 20 miles away from their nearest hospital. Distance and speed of access to services was an important factor in this question.

“If you say go to A and E, that makes me really anxious. Just the thought of going there and all the other patients...you wait around for hours. My local hospital is too big, I’d freak out.”

Some patients did not visit Velindre during their experience and would prefer to remain under the care of the team they know and trust in their own health board area. The importance of knowing the environment as well as the people was fundamental during a difficult time. Some concerns also highlighted a lack of trust in joined-up communications across the NHS.

“For me it’s about familiarity. The anxiety and fear that I have is that nobody knows me and when I’m feeling at my worst I’m going to have to spend a period of time bringing people up to speed on my journey and that is just...quite a dramatic scenario you find yourself in...and how are they going to help me? I have to tell them everything. Wherever you start your journey, it should remain in that place. You want it to be home.”

For those living further afield, alternatives to being admitted to hospital were discussed, for example having a video call consultation which would avoid the anxiety of having a hospital admission. Support needs to be consistent and appropriate to the severity of illness.

“I’m 40 miles from Velindre so if I was feeling rotten I really wouldn’t want to go to Velindre, even though I’d like to go there for the experts. What I’d really like is a Zoom call to Velindre so I can speak to an expert, an online conversation where they could see me...and then if I really had to go there I’d bite the bullet but at least I’ve seen someone first.”

Concerns were raised around the level of support patients would experience at home and especially for those who live alone.

“You need to think about the added pressure and responsibility this puts on your loved ones if you stay at home. If you’re that unwell you should be in a medical environment. I don’t think it’s fair to put that additional burden on them...when I was at my most unwell.”



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My wish is to remain at home with support for me and my family. The transportation to hospital, whether that be via patient transport, ambulance or via family adds additional stress.

Important that there's a strong support plan in place, consistency regarding the people supporting me is key for one. Slightly concerned that being at home could put more responsibility and pressure onto loved ones at an already difficult time for them

I would feel safe knowing I was at the hospital with medical professionals in case my symptoms got worse.

I have chosen at home with support as my answer but I feel equally safe being admitted to hospital.



Arriving at Hospital

Although I would prefer to get to hospital by myself, if arriving using hospital transport you would be taken direct to admissions, where arriving via your own transport this would not be the case.

I'm a long way from a hospital, and public transport is poor here, so it might be really difficult to get to hospital by myself. Also, I'd want the hospital to be prepared for me, which perhaps is more likely if I'm in an ambulance.

I have the ability to get to hospital myself, therefore, I wouldn't want to take up hospital transport which someone else could potentially benefit from who isn't able to get to hospital themselves.

I was in for the day once through treatment and I was taken by a friend which felt better as didn't want to waste anyone's time

“Does it make a difference to how quickly I’d be treated when I got there? Would I be seen faster if I was in an ambulance? If I was feeling really awful all I’d want is to see someone as soon as possible.”

“I’m not totally well-served where I live, the nearest hospital is nearly 20 miles away. I certainly wouldn’t be driving myself all the way to Velindre if I felt unwell.”

“If I had an online face to face conversation before then I might be reassured that there was no need to go anywhere...but if I had to go anywhere, wherever I was going might be primed first...and expecting me....because of the consultation.”



Theme Four - My Team

Wherever patients had been treated, they spoke of the importance of their relationship with their team. Overall, participants were positive about online communications where appropriate but also noting the previous conversation around consideration for those patients who are digitally excluded.

“Visual is very important to have that connection. I insisted on this...obviously it’s the next best thing to face to face.”

“It’s not as good as face to face but it’s better than over the telephone. The times we’re in at the moment, I think we have to get used to it.”

Responses ranged from 82% to 100% in favour of video consultation in order to speak to their clinician sooner.

Nothing can ever replace face to face meetings, but virtual face to face meetings also has benefits. If you feel too unwell to travel to your clinic appointment would be one example. These meetings can take place with multiple participants, family member/carer who perhaps would not be able to attend a face to face meeting.

A very proactive approach for scan results. However, in my opinion new lumps & bumps would need to be physically seen by the consultant.

When discussing local teams managing care instead of known clinicians, there was less agreement with responses ranging from 9% to 100% (average 52%) indicating that personal preference plays a large role in this scenario, and is largely based on lived experience.

“Out of all of it, communication is the number one issue...you’re seeing different doctors and even though your notes are at the bottom of the bed...you’ve got to go through the whole history of it every time. It’s very, very hard.”



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For me consistency of who I engage with is very important. Your team know you better, your case history etc. Any difficult messages should certainly be from your known team

I would have every confidence as they are part of the team.

Continuity of care matters, and so does expertise.

I wouldn't have confidence in anyone outside of Velindre managing my care.

The local team would need to be fully up to date with my care.

As long as the standard of care is the same it shouldn't be a problem.

“Velindre is where the experts were...and that's where I'd want to go.”

“Building that trust is so important. I've got a palliative nurse but because I'm doing well I'm not building those relationships because I'm not seeing them. The only time you get to see them then is when you're in that vulnerable state. Maybe it's down to me....but because I don't feel I need them yet I'd feel like I was wasting their time accessing those services.”

“When Mum was admitted acutely into Velindre I don't think she saw the same team so you have to just accept who is in front of you....but I think we just felt it was one big team.”

When thinking about discussing new developments and having potentially difficult conversations, participants were keen to stress the importance of timeliness of message, with 90% choosing to speak with a senior nurse who could link with their team instead of either waiting to speak to their own consultant (0) or speaking to the on-call consultant that day (10%).

“It would never occur to me that it would be an issue... I would trust that doctor or nurse to know exactly what my diagnosis was...and what my situation was and how they were going to deal with it.”

“If I was to be admitted in to another hospital...because of my experience with communications between each hospital...I wouldn’t have confidence that they knew exactly what was best for me. It’s personal experience that I would feel that way.”

As long as it was handled sensitively and they gave you all of the information, I don't think it would bother me who gave that information to me.

I think it would bother me if I'm honest... depending on what the news was...I'm big on relationships, confidence, the ability to allow people into my world and my confidence to trust people. If I trust them, I'm much more likely to open up with any thoughts or questions I've got for them

It should be efficient to speak with a team member.

Expertise and someone who knows my circumstances matter most.

Workforce Report provides the following:

- Overview of Key Performance Indicators for Sickness, PADR and Statutory and Mandatory training
- A 12 monthly trend report for Sickness, PADR and Statutory and Mandatory training with narrative to explain the data

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted)	Current Month	Previous Month	Target
	Sep-20	Aug-20	
PADR	66.25	63.96	85%
Sickness	5.23	5.20	3.54%
S&M Compliance	80.57	82.99	85%

Workforce Dashboard Highlights

Data below highlights rolling figures for workforce KPI's. This provides a running total of the values of the last 12 months of an indicator providing trend data for the indicators. Granular monthly data is generated for divisions as separate reports. Data Rag Rated for ease of reading.

Key	85%-100%		50% - 84.99%		0% - 49.99%								
PADR	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Corporate	66.67	66.99	73.53	79.00	73.00	71.88	65.35	59.80	51.46	43.93	41.28	37.61	41.96
Research, Development & Innovation	36.96	32.50	32.50	33.33	86.49	87.50	83.72	71.43	72.50	69.77	70.45	67.39	68.89
Transforming Cancer Services	23.08	7.69	61.54	84.62	84.62	78.57	64.29	69.23	69.23	75.00	61.54	60.00	56.25
Velindre Cancer Centre	75.58	72.31	73.46	74.31	70.49	69.66	68.68	64.78	60.26	58.52	62.75	65.67	69.42
Welsh Blood Service	86.04	84.92	85.43	85.68	85.75	84.75	78.00	73.57	67.25	64.94	65.11	67.80	67.58
Velindre Organisations	76.29	73.99	75.94	77.09	76.38	75.43	71.89	67.51	62.28	59.89	61.92	63.96	66.25
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85
Key	85%-100%		50% - 84.99%		0% - 49.99%								
Stat and Mand Compliance (10x CSTF)	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Corporate	76.81	76.42	76.89	77.11	77.04	76.47	74.21	72.36	70.73	68.94	70.00	72.80	66.67
Research, Development & Innovation	60.59	60.20	61.04	59.58	68.57	74.00	74.51	75.10	75.92	76.27	75.96	80.79	72.41
Transforming Cancer Services	72.31	70.00	69.23	80.00	82.31	77.50	77.65	74.38	69.41	65.29	66.67	70.99	70.00
Velindre Cancer Centre	75.47	75.55	76.62	77.05	78.10	79.11	78.16	77.94	77.76	77.62	78.82	79.87	77.79
Welsh Blood Service	90.90	91.22	90.96	91.88	90.85	90.68	92.26	92.87	93.27	93.79	93.79	91.99	90.65
Velindre Organisations	79.94	80.00	80.60	81.15	81.75	82.30	82.08	82.00	81.83	81.74	82.49	82.99	80.57
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Corporate	4.65	4.79	4.93	4.92	4.84	4.70	4.77	4.85	4.85	4.87	4.91	5.20	5.37
Research, Development & Innovation	3.44	3.54	3.42	3.91	4.07	4.02	4.16	4.36	4.68	5.01	5.14	4.87	4.71
Transforming Cancer Services	10.02	8.57	7.17	5.77	4.90	4.17	3.91	3.99	3.81	3.69	3.08	2.46	2.39
Velindre Cancer Centre	4.01	4.02	4.05	4.15	4.25	4.30	4.62	5.06	5.25	5.44	5.56	5.62	5.69
Welsh Blood Service	4.79	4.80	4.79	4.82	4.76	4.83	4.99	5.13	5.09	4.92	4.76	4.60	4.54
Velindre Organisations	4.36	4.37	4.38	4.44	4.47	4.49	4.73	5.03	5.13	5.19	5.21	5.20	5.23
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
Monthly Special Leave Absence %													
Special Leave Non Covid Related	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Corporate	0.00	0.39	0.13	0.19	0.94	0.90	0.68	0.74	0.72	0.11	0.00	0.00	0.21
Research, Development & Innovation	0.00	0.65	0.20	0.00	0.00	1.73	2.41	0.58	1.22	0.00	0.30	1.15	0.17
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.19	0.00	0.00
Velindre Cancer Centre	0.37	0.34	0.38	0.35	0.30	0.40	0.43	0.46	0.39	0.22	0.28	0.39	0.62
Welsh Blood Service	0.27	0.21	0.61	0.43	0.55	0.82	0.72	0.82	0.50	0.48	0.58	0.54	0.58
Velindre Organisations	0.29	0.31	0.42	0.34	0.42	0.62	0.60	0.60	0.48	0.28	0.35	0.42	0.55
Monthly Special Leave Absence %													
Special Leave Covid Related	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Corporate	0.00	0.00	0.00	0.00	0.00	0.00	1.04	2.07	0.86	0.83	0.83	1.86	1.03
Research, Development & Innovation	0.00	0.00	0.00	0.00	0.00	0.00	6.18	5.04	3.46	3.42	3.40	1.83	0.00
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	0.00	0.00	0.00	0.00	0.00	0.06	3.65	5.33	3.84	3.17	2.62	1.80	1.34
Welsh Blood Service	0.00	0.00	0.00	0.00	0.00	0.00	1.98	4.00	3.13	3.17	2.18	1.27	0.79
Velindre Organisations	0.00	0.00	0.00	0.00	0.00	0.04	2.93	4.54	3.28	2.92	2.31	1.62	1.07

PADR – The Figures

PADR Status - last 12 Months by Division



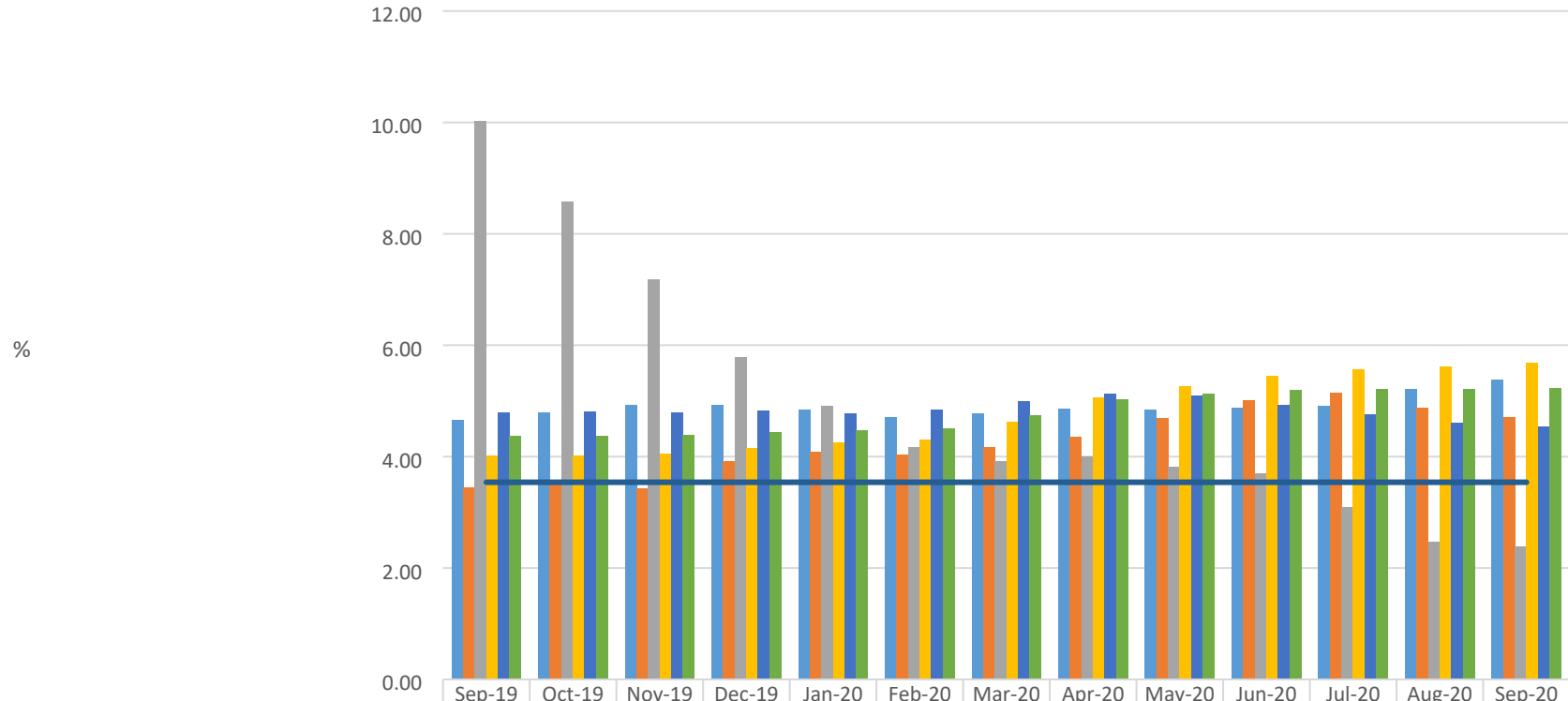
PADR – The Narrative

Organisational Context PADR	Issue	Actions	Timelines
<ul style="list-style-type: none"> Impact of COVID impacting on PADR completions 	Compliance below 85% KPI rate	As we move to Recovery Phase local target plans to improve compliance and target hotspots ongoing. Local plans will include aligning PADR dates with pay progression	Local plan monitored via SMT monthly meetings, WOD committee and Senior WOD Team meetings
		Guidance on PADR completion rolled out via WOD Business Partners and Workforce information supporting to ensure PADRs on ESR	Guidance issued, ongoing support
		Sharing of good PADR practice compliance via the Education and Training Steering group	PADR standing agenda item on the Education and Training Steering Group
		Focus on managing development and succession planning to support PADR conversations and development	Re introduction of talent management pathways development work, completed for informatics, medical physics, management development
	Performance Management of PADRs	Triangulation of data in hotspot areas of poor PADR compliance is ongoing to ensure data provides	Triangulated performance reports provided to SMT

		<p>effective information on the issues</p> <p>HR linked to hotspot areas and implementing an appraise and support approach to effective PADR management, ensuring best practice is shared</p>	<p>Ongoing development of report to benchmark in NHS Wales and UK wide</p>
		<p>Improved reporting to Heads of Departments, via sharing monthly PADR data by WfOD to encourage local and timely conversations identifying any barriers to completing PADRs. Escalated as required to Workforce Information, LED Team or Business Partners.</p>	<p>Template for information to be developed by end of November with the intention to share with managers in December 2020.</p>

Sickness Data – The Figures

Sickness - Last 12 Months by Division



Corporate	4.65	4.79	4.93	4.92	4.84	4.70	4.77	4.85	4.85	4.87	4.91	5.20	5.37
Research, Development & Innovation	3.44	3.54	3.42	3.91	4.07	4.02	4.16	4.36	4.68	5.01	5.14	4.87	4.71
Transforming Cancer Services	10.02	8.57	7.17	5.77	4.90	4.17	3.91	3.99	3.81	3.69	3.08	2.46	2.39
Velindre Cancer Centre	4.01	4.02	4.05	4.15	4.25	4.30	4.62	5.06	5.25	5.44	5.56	5.62	5.69
Welsh Blood Service	4.79	4.80	4.79	4.82	4.76	4.83	4.99	5.13	5.09	4.92	4.76	4.60	4.54
Velindre Organisations	4.36	4.37	4.38	4.44	4.47	4.49	4.73	5.03	5.13	5.19	5.21	5.20	5.23
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

Sickness – The Narrative

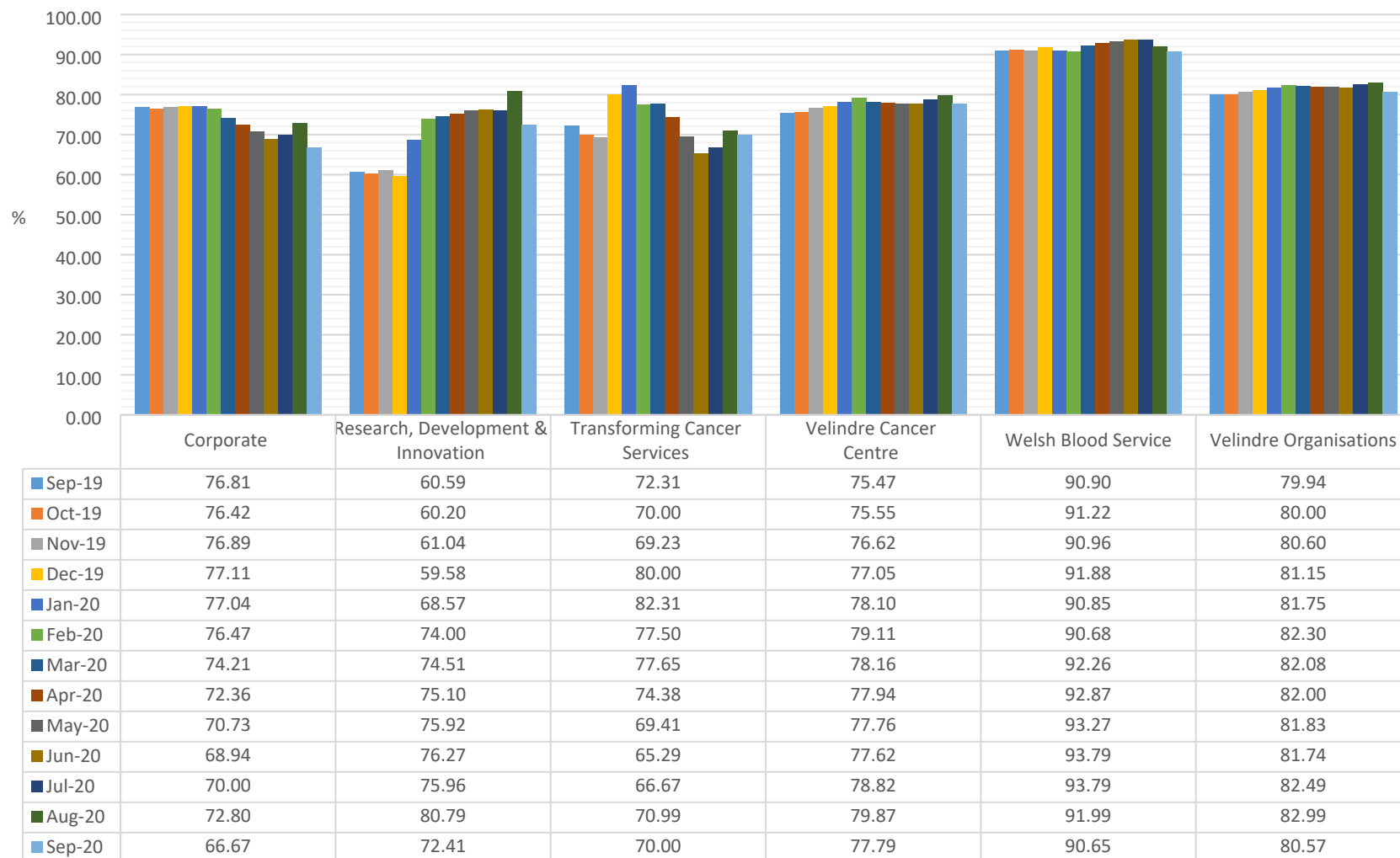
Organisational Context Sickness	Issue	Actions	Timelines
<ul style="list-style-type: none"> • COVID Related absence sickness not always work related • Dedicated focus on staff's physical and psychological wellbeing 	COVID related absence	<ul style="list-style-type: none"> - Daily wellbeing updates in Trust communications to signpost internal and external interventions and resources, this includes webinars; support lines; tools; resources for families etc - Creation of the Trust H&WB internet and intranet pages to support all staff during and after the pandemic, ranging from Self Care, EAP, Financial Wellbeing, Manager Support - Staff support via the Psychology Team –; 1-2-1 support; including support to colleagues not based at VCC; Virtual sessions for managers on supporting your team (delivered via MSTeams) - Also includes WOD support available via interventions such as coaching - Offering staff places to recharge – Wellbeing Room at WBS 	Monitored via Workforce Cell

		<ul style="list-style-type: none"> - WOD & Psychology Team developing a session for managers on 'Identifying the Signs of Stress / Anxiety and Having those conversations with your team' - EAP reminder to staff included in Trust Communications and outlined clearly on H&WB pages (including Manager Assist) 	
		Development of an anonymous staff feedback tool – Work In Confidence – enabling and encouraging a safe environment to raise concerns; put forward ideas etc.	October 2020
		Linking in with national agenda (NHS Wales; NHS Improvement) to prepare and enhance interventions to support staff in recovery phase (e.g. monitoring; wellbeing champions; refocus as 'Time to Change Wales' employer – MH Awareness training etc;)	Ongoing reviewed in Workforce Cell
		Currently developing H&WB plan into recovery phase where staff are more likely to require support (based upon CARE	June 2020

		model – create, assist, rapid, engage)	
		<p>Improved reporting to Heads of Departments, via sharing monthly sickness absence data by WfOD to encourage local and timely conversations identifying ‘hotspots’ and trends, escalating as required to Business Partners.</p> <p>To ensure that the proactive wellbeing approach is embedded within management practice through these local monthly discussions, maximising attendance of staff.</p>	<p>Template for information to be developed by end of November with the intention to share with managers in December 2020.</p>

Statutory and Mandatory Figures – The Figures

Statutory & Mandatory Compliance (10x CSTF) last 12 months by Division



Statutory and Mandatory Figures – The Narrative

Organisational Context	Issue	Actions	Timelines
<ul style="list-style-type: none"> Baseline is compliant with the 10 Core Skills Training Framework Level 1 Essential requirement for staff training is within individual compliance matrix, learning page in ESR Accuracy of data within ESR on what mandatory and statutory requirements 	Compliance below 85% Welsh Government requirement	Mandatory and Statutory Focus Group set up to share best practice, membership includes Trust trainers and Subject Matter Experts	Held quarterly
		Guidance leaflets produced and circulated on how to access training	Guidance issued – on going support
	Staff unclear what training they need to undertake for their role	Training needs analysis produced identifying levels of CSTF needed for each staff group and what is mandatory, this now includes COVID related training	CSTF data uploaded into ESR, COVID data being developed
	New staff requirements not aligning to current position numbers	Monthly reports from ESR on new starters given to the Education and Development team to check requirements and alignments	Beginning of each month commencing 2020.
	Not all staff are familiar in the usage of ESR and access to training	Dedicated computer training sessions, with laptops and support for all staff organised on different dates/times to accommodate shifts patterns – drop in sessions	Regular sessions planned throughout the Trust for 2020

<ul style="list-style-type: none"> Culture of Education and Development 	Training is not highly regarded with some areas of the Trust	Education Steering Group established to identify priority through IMTP, agree KPI's for work plans and hold to account, support divisions to provide detailed plans for educational support	Meetings held quarterly
		Provision of detailed reports to departments/Committees on staff compliance	Ongoing
		Department encouraged to develop action plans to increase compliance	M&S Focus Group action
		High level compliance encouraged to provide visibility and leadership	Executive /Senior Managers
	Release of staff to attend training	Virtual Reality project underway with Fire Clinical Training, current requirement to attend classroom, future will be staff can access this training at a time and place which is convenient making access to training more flexible	Pilot within Integrated Nursing March 2020 rollout delayed due to COVID
		Improved reporting to Heads of Departments, via sharing monthly M&S data by WfOD to encourage local and timely	Template for information to be developed by end of November with the intention to share with

		conversations identifying any barriers to completing training requirements. Escalated as required to Education & Development or Business Partners.	managers in December 2020.
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COVID19 Related Workforce Absence

Absence Type	Sunday 1st Nov 2020	Sunday 8th Nov 2020
Overall Sickness FTE %	4.44%	4.12%
	Headcount	Headcount
COVID Sickness	15 Staff	14 Staff
Non COVID Sickness	55 Staff	52 Staff
COVID Special Leave	18 Staff	24 Staff
Non COVID Special Leave	4 Staff	3 Staff
Total	92 Staff	93 Staff

- ESR BI used as reporting mechanisms for absence.
- Below is Organisational Sickness & Special Leave absence as at Sunday 8th Nov 2020 COVID-19 only:

Division	H/C Sickness	H/C Special Leave	H/C within Division	% Sickness of Division	% Special Leave of Division
Corporate (Inc. TCS and RDI)	1	1	205	0.49%	0.49%
Velindre Cancer Centre	10	14	831	1.20%	1.68%
Welsh Blood Service	3	9	479	0.63%	1.88%
Hosted (HTW and CRW)	0	0	21	0.00%	0.00%
Total	14	24	1536	0.91%	1.56%

Workforce Absence

All Sickness Absence Rolling as at Oct 2020
(Covering 12 Months)

Month	Rolling Abs FTE %
Reported in Oct 2020	5.19

Covid Sickness Absence Rolling as at Oct 2020
(Covering 12 Months)

Month	Rolling Abs FTE %
Reported in Oct 2020	0.67

Absence reasons from Nov 2019 - Oct 2020

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	161	189	8,183.33	33.5
S15 Chest & respiratory problems	251	280	2,890.02	11.8
S12 Other musculoskeletal problems	52	58	2,108.44	8.6
S28 Injury, fracture	37	39	1,794.37	7.3
S11 Back Problems	47	55	1,268.13	5.2
S13 Cold, Cough, Flu - Influenza	248	280	1,249.55	5.1
S25 Gastrointestinal problems	201	234	1,006.60	4.1
S27 Infectious diseases	63	65	799.10	3.3
S19 Heart, cardiac & circulatory problems	22	24	770.24	3.1
S17 Benign and malignant tumours, cancers	8	10	725.40	3.0
S98 Other known causes - not elsewhere classified	18	18	634.53	2.6
S30 Pregnancy related disorders	29	50	612.71	2.5
S21 Ear, nose, throat (ENT)	65	70	420.42	1.7
S26 Genitourinary & gynaecological disorders	59	71	396.09	1.6
S29 Nervous system disorders	6	6	376.12	1.5
S16 Headache / migraine	90	103	368.21	1.5
S24 Endocrine / glandular problems	10	13	361.91	1.5
S23 Eye problems	12	14	146.97	0.6
S31 Skin disorders	9	11	110.47	0.5
S18 Blood disorders	5	8	106.02	0.4
S22 Dental and oral problems	14	14	45.16	0.2
S99 Unknown causes / Not specified	10	10	44.67	0.2
S14 Asthma	6	7	38.60	0.2

TRUST BOARD

WELSH BLOOD SERVICE DIVISIONAL REPORT

DATE OF MEETING	26/11/2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable	
PREPARED BY	ALAN PROSSER, INTERIM DIRECTOR, RACHEL HENNESSEY, GENERAL SERVICES MANAGER PETER RICHARDSON HEAD OF QUALITY ASSURANCE AND REGULATORY COMPLIANCE	
PRESENTED BY	Alan Prosser, Interim Director WBS	
EXECUTIVE 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
Operational Management Group Executive Management Committee	26/10/20 02/11/20	Discussed Discussed

Quality, Safety and Performance	12/11/2020	Discussed
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ACRONYMS	
WBS MHRA RAGG SAE	Welsh Blood Service Medicines and Healthcare products Regulatory Agency Regulatory assurance and governance group Serious Adverse Events

1. SITUATION

This paper is to provide the Quality, Trust Board with an update on the key quality, safety and performance outcomes and metrics for the Welsh Blood Service for the period to the end of September 2020

The Trust Board is asked to **NOTE**:

- Progress against key priority areas
- Issues, corrective actions and monitoring arrangements in place
- Service developments within WBS

2. BACKGROUND

This report is a summary of key operational, quality, safety and performance related matters being considered by the Welsh Blood Service during September 2020, and has been prepared in readiness for the newly defined Velindre University NHS Trust Board and Committee governance arrangements. The report also highlights key programmes taking place across the Division.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The main report provides summarises:

- Key performance outliers and associated actions to resolve
- Key quality and safety related indicators and remedial action identified
- An overview of WBS position in relation to Welsh Government COVID guidance.

- Key themes arising from the donor satisfaction survey for September and action taken to address areas of concern.
- Regulator and Audit Feedback, assurance and learning themes
- Critical and Significant Trust/divisional Risks
- An outline of key service developments in WBS
- Successes and exceptions across the service

3.1 Triangulated Analysis

The report provides assurance to the Quality, Safety and Performance Committee that WBS is continuing to meet its Quality, Safety and Performance standards.

To summarise for the month of September 2020:

- All clinical demand was met at the end of September.
- All blood stock groups were maintained above the required 3 day target.
- All clinical demand for platelets was met.
- 90% of quality incidents closed within the required 30 days. This meets the target position. This indicates a 10% improvement in performance from the previous month.
- No Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in September.
- One formal concern requiring a formal response in 30 days was received in September.
- All concerns were acknowledged within 2 working days of receipt, in line with target.
- Overall donor satisfaction continued to exceed target position at 96%.

3.3 Key Actions / Areas of focus during next period

Moving into quarters 3 and 4 of the financial year, the service is focussed on a maintaining a supply of blood, in light of the second wave of COVID and an approaching winter. This will also be alongside the launch of the plasmapheresis service.

In addition, the service is preparing itself for an on-site MHRA inspection following on from the virtual table-top inspection in early September and for a No Deal at the end of the EU transition period (December 31st 2020).

Continuous engagement with donors, staff and key stakeholders will be key going forwards and the service is preparing to update the national Community Health Councils forum for Wales on the current changes made to the collection model due to COVID and challenges moving forwards.

Quality and safety will remain at the heart of our service during this period in all aspects of service delivery as will the well-being of our staff.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: <ul style="list-style-type: none"> • Staff and Resources • Safe Care • Timely Care • Effective Care.
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. RECOMMENDATIONS

Trust Board are asked **NOTE** the information in this report.

WELSH BLOOD SERVICE - TRUST BOARD REPORT

August 2020

1. INTRODUCTION

This is the first paper produced from WBS for the revised Quality Safety and Performance Committee.

2. TRUST BOARD PERFORMANCE REPORT

2.1 Deep Dive Assessment: Quality, Performance & Outcomes – By Exception

Performance Highlights for September 2020

See Appendix 1

The table below provides an overview of the areas where the performance target **was not met** for September 2020 and the actions being taken to address this.

No.	Key priority Area / Indicator	Description	Reason for Variance	Current Position & Monitoring Arrangements	Remedial Actions	Completion Date
1.	Number of new bone marrow donors per month (target 4000 per year/333 per month)	There were 242 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in September.	COVID has had an impact on donor behaviour and session capacity is limited.	Group has been established to take forward recruitment of non-blood donors	<p>Develop a new donor recruitment and retention strategy for the WBMDR aligned with the development of the revised WBS strategic intent.</p> <p>The new Donor Recruitment & Retention Strategy will be informed by:</p> <ul style="list-style-type: none"> - a review of the existing donor panel to assess the required growth; - a review of the outcomes of the new bone marrow pilot recruitment 	On hold due to COVID pandemic

					to provide proof of concept and operational readiness for a recruitment strategy that is not solely dependent on blood-donors.	
3.	Collection Efficiency (Whole Blood) - The number of collected units by wte by hour Target 1.25	Collection efficiency is below the target at 1.11	This is a consequence of the ongoing need to increase resource requirements due to COVID 19, which has resulted in additional staffing being sent out per team to man a newly added triage point, and to support the introduction of social distancing and PPE. Depending on the number of chairs put out, this could see an increase of up to 3 staff per team. This is likely to continue for the long term while COVID 19 is present within the community. However a	Blood Supply Chain 2020 Initial meeting recommenced October 2020.	The changes which were due to be brought in under the Blood Supply Chain 2020 have been put on hold during the COVID 19 pandemic.	March 2021

			small improvement has been seen due increase in collections to meet demand and this has been sustained improvement for the past 3 months.			
4.	Manufacturing efficiency	Production efficiency continues to remain below the target.	The principle influences on this are lower collections due to current COVID conditions and increased staffing in line with recruitment to ambient overnight hold.	BSC2020 Initial meeting recommenced October 2020.	Target to be reviewed in line with processing / staff changes as part of the Blood Supply Chain 2020 initiative.	To be reviewed following re-establishment of BSC2020
5.	Time expired platelets	Time expired platelets was above target of 10% for September at 25.29%	<p>The is as a result of increased production to cover the bank holiday at the end of August and in the third week following reduced demand.</p> <p>Overall wastage was down compared to previous months (except August) but production has also been reduced so the % wastage increased.</p>	Ongoing monitoring	Further planned reduction in platelet production will continue.	This will be an iterative implementation over a period of time that will continue to be impacted on by external factors and as such does not have a definitive deadline.

6.	Number of new blood donors	<p>Number of new donors was lower than numbers necessary to support an annual target of 11000.</p> <p>Current position is 5155 donors at end of September 2020</p> <p>582 new donors completed a donation in September</p>	Limited capacity at donation sessions across Wales has meant fewer opportunities for new donors to donate.	ongoing	Venue capacity is limited considering social distancing measures in place to meet COVID requirements.	ongoing
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3. KEY DISCUSSIONS ARISING FROM THE AUGUST 2020 WELSH BLOOD SERVICE REGULATORY ASSURANCE AND GOVERNANCE GROUP (RAGG)

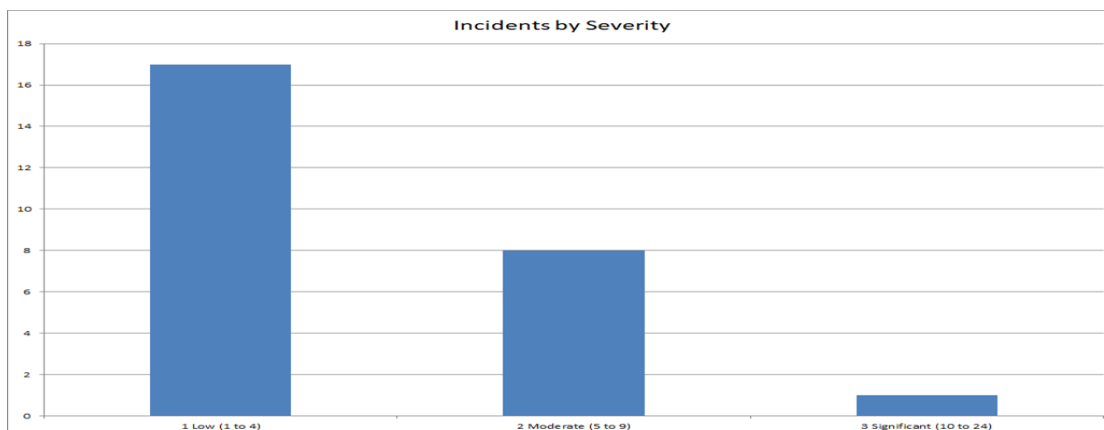
With effect from the August 2020 meeting, RAGG has resumed its full agenda of standing items and reports, which was pared back at the start of the COVID pandemic to focus on patient/donor safety and regulatory matters. The following matters were discussed:

- New tolerance levels have been agreed for the different categories of donor adverse events.
- Support was given for a nurse-led trial of microbial swabs following arm cleansing prior to venepuncture.
- It was noted that the recent upward trend in positive bacterial tests for platelets had reversed following a review of processes in laboratories.

4. HOW SAFE IS OUR SERVICE

Incidents

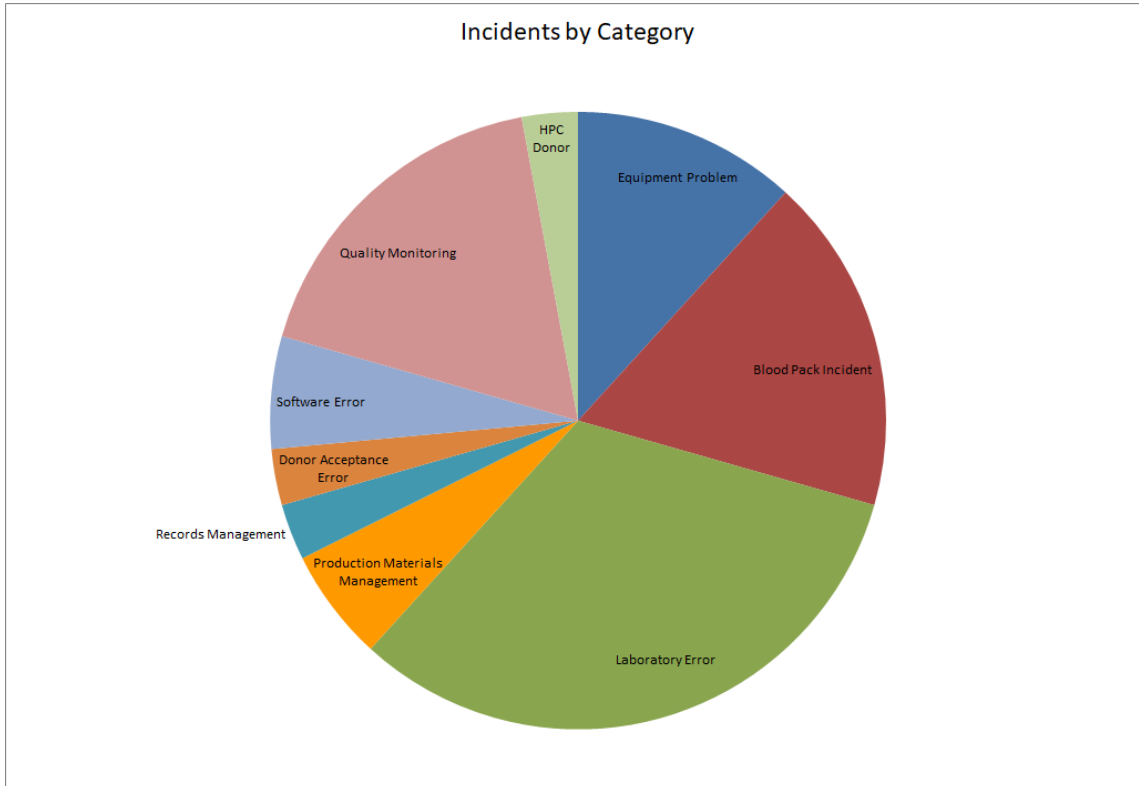
There were 26 Good Manufacturing Practice (GMP) Incidents reported in September this is the same number as in August, these fell into the following severity scores:



The 'Significant' Incident was a loss of environmental monitoring data for 45 minutes as a result of a planned software update by the system supplier. The system had been constantly monitored during this period with no alerts reported, and there is no risk to product quality or patient safety. The incident was assessed as 'Significant' as an important part of the audit trail was lost. This has been raised with the system supplier and escalated to their executive team.



Incidents by Category



There were 10 laboratory errors reported in September which is an increase on the recent trend of 6 per month, the underlying reason for this increase is under investigation and the findings will be reported via RAGG.

In the 3 months to the end of September 2020, 90% of reported incidents were investigated and closed within 30 days. This is an improvement on the previous 3 months and details of the incidents closed late have been shared with SMT leads for follow up with their teams. The Quality Assurance team will continue to highlight those open incidents with an approaching deadline to Heads of Department at the start of each month.

No new SABRE reports were submitted to MHRA in September.

Meeting COVID requirements

- Addressing accommodation and site requirements

See Appendix 2

WBS is continuing to monitor delivery against Welsh Government guidelines and legislation. The document attached provides details of compliance against these guidelines.

During the month of September, there have been no areas of concern identified in relation to meeting accommodation and site requirements.

In order to provide further assurance, from November, WBS will have a process in place to ensure there is a monthly checklist of compliance against these guidelines and a number of temporary COVID SOPs which have been developed, including: contractors on site, transport arrangements.

COVID19 risk summary

Currently there are 20 open risks linked to Covid-19 on the Risk Register. Of these, 14 are rated as significant and one as critical. These numbers are unchanged from last month.

Details are given below of all Significant and Critical risks:

Title	Department	Description	Potential Effects of Failure	Rating (Target)	New RPN
Exposure to Potential Pre-symptomatic, Asymptomatic Individuals at Verification Sample Procurement, Donor Information, Medical Assessment and Stem Cell collection.	Welsh Bone Marrow Donor Registry	Donor Exposure to potential pre-symptomatic, asymptomatic individuals at VT sample collection - Performed by a Health Care at Home under contract to the WBMDR.	Donor at risk of contracting the COVID-19 infection.	10	Significant (score 10-24)
Impact of COVID-19 stabilisation phase to WBS	Affecting Whole Service	Re-introduction of elective procedures including Haematology activities. WBS are aware that WG have written to all Health Boards regarding the re-introduction of this work.	WBS may experience a sudden increase in demand for blood components. The increase in demand may not be consistent from all customer hospitals and will be dependent on their internal activities. Current blood collection model may not be aligned to meet this demand.	12	Significant (Score 10 to 24)
Impact of COVID-19	Affecting Whole	As part of the revised blood collection model in WBS response to	WBS may lose suitable venues or may not be in a position to maintain current blood	12	Significant (Score 10

stabilisation phase to Collections	Service	<p>the COVID-19 pandemic, a number of static sites were secured as Organisations closed in response to Government guidelines. WBS have been using these sites on a static weekly basis and this has assisted with social distancing guidelines.</p> <p>Once Government guidelines are removed Organisations will open back up and WBS may not be in a position to use the venues at all, or for the time duration currently identified. This may result in WBS reverting to an alternative blood collection model/venue.</p>	<p>collection model or comply with social distancing guidelines.</p> <p>This may also impact on the ability to achieve blood collection targets. WBS may see a sudden increase in demand as surgery/Haematology procedures come back online.</p>		- 24)
Covid-19 implications of handling biological samples within the WBS	Laboratory Services	Handling of untested or presumed COVID-19 negative samples for laboratory testing	COVID-19 infection is related to a range of outcomes from asymptomatic / minor infection to serious illness and potentially death.	20	3 Significant (10 to 24)
Introduction of Additional PPE on Collection Teams - COVID-19	Clinical Services- WBS	Reduce transmission of COVID-19 in the blood donation setting by implementing recommendations in revised PHW guidelines (applicable to all staff who work in or visit any donation clinic setting)	Virus is transmitted, Staff member / other donors become infected	24	3 Significant (10 to 24)
Childcare provision for VUNHST staff during COVID-19	Human Resources- WBS	Inability to operate core services due to schools not able to offer childcare provision to key workers during COVID19 pandemic.	Reduction in workforce, inability to maintain business as usual and support critical services.	12	Significant (Score 8 - 12)

Clinical Audit

Clinical audit at the Welsh Blood Service is fundamental in ensuring optimal clinical care outcomes for our service users. To effectively deliver the clinical audit function the Welsh Blood Service are realigning Clinical audit roles, responsibilities, structures and areas of work to develop a robust Clinical Audit Plan.

5. HOW EFFECTIVE & EFFICIENT IS OUR SERVICE

WBS participates in an annual European Blood Alliance (EBA) benchmarking report. This is currently undergoing validation within the service and the report will be issued later in the financial year.

SMT have reviewed the Health and Care standards framework and allocated responsibility for each standard to a named SMT lead. Work is underway to ensure these standards are embedded in all core business and planning decisions.

6. WHAT OUR DONORS ARE SAYING

Donor Satisfaction

WBS invites every blood donor to complete a feedback survey in the month after their donation. This is available online, by text message or by completion of a feedback form. 3680 emails successfully sent and 1371 completed responses (37.3% response rate) were received

Overall donor satisfaction for the month of September continued to exceed target position at 96%.

Work is continuing to analyse the response. However, the following should be noted:

- 1,059 (77% of the completed responses) donors rated the service six out of six.
- All respondents who scored their satisfaction as one (11 respondents) or two (9 respondents) out of six, were offered the opportunity to provide qualitative feedback. The responses below were received. Action relating to these issues is being collated

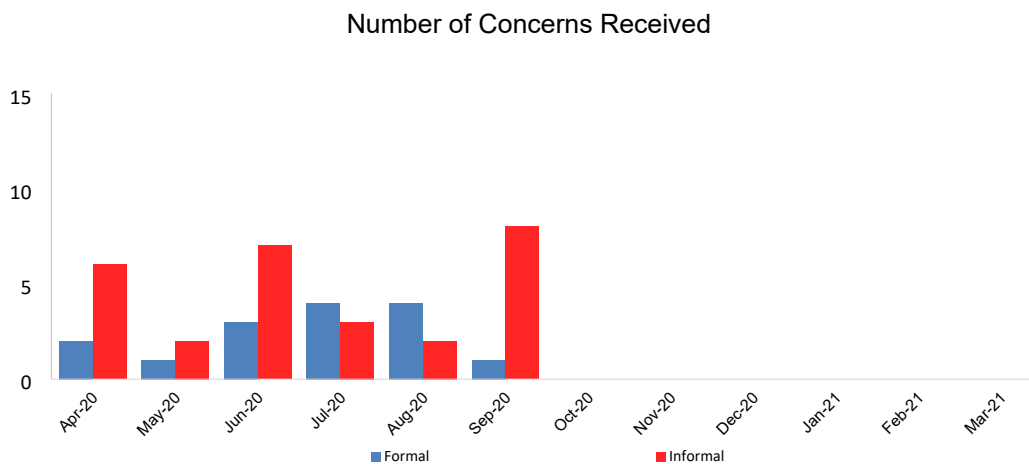
Key themes	Response/Action
Donor requirement to wear masks	<p>There is a requirement for donors to wear facemasks. At present we are unable to make exceptions for individuals who are exempt from wearing facemasks as we have a duty of care to staff and the other donors.</p> <p>Donors are advised on booking that they are required to wear a facemask in line with Welsh Government legislation during the COVID pandemic.</p>

	<p>We are working with the Trust to ensure an equality Impact Assessment is completed in relation to this area.</p> <p>Guidance is being sought from our legal team in relation to this.</p> <p>We are revisiting whether we can appropriately allow donors with exemptions to donate whilst maintaining safety for all.</p>
Discomfort/unhappy with donation procedure	<p>Training and Clinical Services teams continue to analyse adverse events to identify trends or clusters of events. Both teams continue to work closely with Collections teams to improve donor comfort during the donation process.</p>
Communication between staff taking the blood and the donor	<p>Communication can be hindered by the need to achieve the correct ambient noise levels in the room that assist with donor confidentiality and the wearing of masks by both donors and staff.</p> <p>Operational Managers give feedback to teams on customer service standards and expectations</p>
Temperature of the room	<p>The temperature of the venues where donations take place is monitored as there is also the requirement for a minimum temperature to ensure blood can be collected. We are aware there have been temperature issues within a number of the buildings being used and are actively having discussions with the organisations.</p> <p>We have carried out a specific heating risk assessment and have gained support from Public Health Wales (PHW) for use in negotiating with venue hosts to allow us to use their heating systems.</p> <p>We have purchased a number of portable heaters as resilience measure throughout the winter.</p>
Directional signage for clinic rooms	<p>We will ensure that clear signage is in place at venues for donors attending.</p>
Compliance with social distancing during screening	<p>Staff have been made aware of the need to ensure all social distancing requirements are met. 'Spot check' audits are planned as part of a wider programme to monitor compliance with social distancing measures.</p>
Donors being turned away after arriving late	<p>We are revisiting the clinic SOP regarding approach to late donors.</p>

Donor concerns

In September a total of 7141 donors were registered at clinic.

A total of 9 concerns (0.13%) were reported within this period with 8 being managed as Early Resolution (ER) within 2 working days and 1 formal complaint because the donor requested it to be treated formally.



Reasons for concerns during this period include:

- Wearing of face mask/covering on session when exempt
- Late attendance at clinic
- Not enough information about COVID 19 in text/on website
- Staff parking over driveway
- Temperature checks on clinic
- Deferred at screening

All concerns have been investigated and lessons learnt identified and actioned as appropriate.

The following actions have been undertaken in response:

- A full review of the current SOP COL-027 (Triage Questions) has been undertaken and the document will be updated to ensure clarity.
- Text message reminders now have covid 19 information and a full review of the text messaging reminder service has been undertaken.
- Process changed to now reflect covid 19 updated/information.
- A more focused approach has been adopted for deferrals, being very clear on timeline restriction and staff involved in contacting donors have been made

aware of the requirements. An improvement has been seen this month in terms of staff attempting to contact donors much sooner.

7. WHAT OUR STAFF ARE SAYING and WORKFORCE PERFORMANCE

Workforce Health and Well-being Survey

A Health & Well-being staff survey has been conducted by WOD, during the month of September, to ascertain how staff have felt during the COVID19 pandemic. This is part of a series of health & well-being surveys being conducted by WOD on behalf of the Trust. WOD will be analysing the data in detail and having further discussions on the findings over the next few months

Workforce Performance – Welsh Blood Service

The table below provides a summary status report of workforce and Organisation Development related practice at WBS for the month of September.

ALERT / ESCALATE	<ul style="list-style-type: none"> Highlight, the PADR Compliance is reporting 67.58% this month below the target of 85%. Noted that there have been some difficulties uploading PADRs in ESR. WOD have indicated they will work with Heads of Departments to provide support.
ADVISE	<ul style="list-style-type: none"> Cumulative 12-month average Sickness is reported at 4.54% which is a slight decrease on last month 4.58%. The target is 3.54%. Short Term absence is reporting at 1.58% in September increase from 1.15% in August and long-term absence has increased reporting 2.29% from 1.75% in August. Stress Related absence continues to be the highest reason for absence at 31.9% of all absences over the last 12 months. This relates in the main to individuals experiencing issues outside of the work environment. We are working with WOD to support these staff and look at any further trends, which may be addressed within the working environment. Turnover rate (12 month) reported at 10.87% FTE and 12.16% Headcount significant decrease this month from last 12.25% FTE reported in August.
ASSURE	<ul style="list-style-type: none"> Statutory and mandatory training 90.94%



INFORM

Recruiting Managers Key Performance Indicators

		Average Time in Working Days	
Trac Report Code	Trac Recruitment Health Check	Target	Aug-20
T0a	Notice Date to Authorisation Start Date	5	0.0
T1a	Time to Approve Vacancy Request	10	5.5
T4	Time to Shortlist	3	3.5
T5b	Time to Update Interview Outcomes	3	1.8
T8b	Time to Approve References	2	3.4
T12	Vacancy Creation to Conditional Offer	44	36.1

To note:

This is an improving position on the previous months.

In addition to the standard dashboard, the Annual Leave Balance Report tab has been added, which highlights the high level figures of 'Percentage of leave booked or taken' in each Section.

Section	% of leave booked or taken	% of leave unbooked
120 WBS Clinical Section	64.17	35.83
120 WBS Collection Section	74.88	25.12
120 WBS Directors Section	52.50	47.50
120 WBS General Section	58.08	41.92
120 WBS Laboratory Section	53.85	46.15
120 WBS Quality Assurance Section	58.34	41.66
120 WBS WTAIL Section	57.43	42.57
Grand Total	64.30	35.70

8. WHAT OUR REGULATORS / EXTERNAL / INTERNAL ADULT ARE SAYING

MHRA

No Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in September.

An action plan has been agreed with the Medicines and Healthcare Products Regulatory Agency (MHRA) following the inspection in June 2020. The corrective actions are being managed via an action plan with progress reports to the Regulatory Assurance and Governance Group. Progress reports are shared with the MHRA.

Following the UK Accreditation Service inspection in July, a final submission has been provided in response to the findings reported. The action plan is now closed.

Internal WBS Audits Commenced

Due to the Coronavirus pandemic resulting in the need to potentially move staff around to support priority activities, and the audit team being under resourced at present, it has been necessary to review the 2020/2021 Audit Schedule from April to September.

Non-critical audits were identified for postponement and in some cases risk assessed for closure, to avoid a bottleneck of audits later in the year. The audits closed will be reviewed for completion the early part of the next audit schedule commencing from April 2021/2022.

Audits scheduled for completion in September

There were eight audits scheduled for completion within September:

- Three audits have been completed with Audit Reports received.
- Two audits have been conducted, awaiting submission of audit reports.
- Two Procedural Audits have commenced:
 - 20/18 Stores (MP-029)
 - 20/20 Management and Operation of Apheresis Clinic (MP-027)
- One audit 20/17 audit of Collection Team, has been postponed due to latest Covid-19 lockdown situation. To be reviewed end of October.

The table below outlines Audits reviewed for closure/postponement in August.

Audit Number	Scope	Month Due	Proposed Review Status
20/15	Vertical Audit of full donation cycle – to be conducted within a 3 month period - Postponed, to be conducted following the commencement of the Senior QA Auditor in November	August	Postponed to January 2021
20/16	North Wales Audit (Teams and SHU) – Postponed to January 2021, due to COVID-19 restrictions and following the commencement of the Senior QA Auditor	August	Postponed to January 2021

9. RISKS

The Welsh Blood Service Risk Register is compiled of all risks that have been reported using DATIX. The following high-level risks exist in the WBS and are reported to Trust:-

ID	Title
14764	BREXIT - 'No Deal' Preparation
13343	Orpheus LIMS – (Proposal to EMB/Trust Board to close the current risk re: implementation of Orpheus and create a new risk relating to the contractual changes, liabilities etc associated with de-scoping Orpheus from the WLIMS contract

The following Critical/Significant Risks were raised during September

ID	Title	Review Date	RPN
16266	Blood Collections –Collections Recovery Plan for Covid-19, Sourcing Premium Venues Across Wales.	09/11/2020	Critical
16294	Clinical Services - Implementation of face coverings on donors throughout donation cycle.	14/11/2020	Significant

10. ASSURANCE / LEARNING

The most recent MHRA inspection noted the time taken to investigate and close 'Good Manufacturing Practice' incidents. The QA team have reviewed the process along with operational managers and proposed to expedite the investigation of low-risk incidents. This will allow managers to focus resource on the small number of higher risk investigations to allow for more timely completion. A formal proposal has been approved by RAGG for pilot in Q3.

11. SERVICE DEVELOPMENTS / IMPROVEMENTS

Description	Action
Collections model	<p>The Collections model was reconfigured at the start of the COVID pandemic to address the need to meet with social distancing requirements.</p> <p>As we move into quarter 3 of the financial year, we are Continuing to operate the new Covid-19 clinic model introduced in response to the pandemic with social distancing and donor screening requirements</p> <ul style="list-style-type: none"> • Clinics fully adjusted for social distancing – reduced chairs at most venues • Sessions made 100% appointments – walk-ins removed to improve flow on session • PPE introduced for staff • Triage introduced before registration • Enhanced cleaning introduced between each donor • Donors invited based on proximity of regional hub to their pre-Covid ‘preferred clinic’
Convalescent Plasma	<p>WBS commenced the production of plasma from whole blood collection in Quarter 1 of the financial year. This programme of work has progressed during Q2 and will continue throughout Q3 and Q4 in line with the business case supported by Welsh Government for the production of plasma through the use of plasmaphereses.</p> <p>Plasmapheresis ‘Go Live’</p> <ul style="list-style-type: none"> ▪ Go live by end of October with 10 plasmapheresis machines ▪ Staff recruited and undergoing training

	<ul style="list-style-type: none"> ▪ A regional model with delivery in: <ul style="list-style-type: none"> • Wrexham north Wales • Dafen (Llanelli) west Wales • Talbot Green Wound Clinic South Wales ▪ Service is working with PHW to identify Covid recovered patients and inviting them to Whole blood clinics to donate convalescent Plasma ▪ Those donations of high titre are being issued to all hospitals across Wales to support Clinical trials of the product.
WBS Infrastructure business case	<p>A business case has been submitted to Welsh Government to address three areas:</p> <ol style="list-style-type: none"> 2 Electrical infrastructure 3 Mechanical infrastructure 4 Laboratory modernisation. <p>The Welsh Government scrutiny case will be completed by 23rd October. WG central team will then assess the comments received early the following week and then agree next steps, either:</p> <p>(a) that we will need to respond to comments / provide additional information OR</p> <p>(b) they will advise approval of the PBC and permission to move to the next stage i.e. development of the BJC for phase 1</p>
Support to Welsh Govt to roll out of National Covid vaccination programme 'Operation Ambush'	<p>WBS has been asked to support with the storage, management and technical oversight of NHS Staff vaccines held at –80 centigrade.</p> <p>In addition, use of WBS donor booking appointment system to support national roll out of COVID vaccination programme Booking system and technical expertise.</p>

12. CELEBRATION & EXCEPTION

11.1. Celebration

Award Winner

Maria Burton was announced as a winner at the virtual 2020 Advancing Healthcare Awards, in the 'rising star' category.

Maria was nominated for her determination and commitment to continuous development and learning. Since starting in the WBS in 2010 as a Medical Technical Assistant, then moving to Welsh Transplantation and Immuno-genetics Laboratory (WTAIL) as an Assistant Practitioner, she has gained HCPC registration as a Biomedical Scientist. She was then the first person to complete the IBMS specialist portfolio in WTAIL and is now completing the BSHI Diploma as a Trainee Clinical Scientist. On top of this, the application noted her personal attributes, professionalism and passion for healthcare.

Award finalists

Amy De'Ath, Sandra Lloyd and the WTAIL team were nominated as finalists at the same awards in the hotly contested finalist category, Driving Improvement, Delivering Results is the Scottish Government's award and celebrates healthcare scientists who have demonstrated their expertise to drive improvement and maximise the contribution of healthcare science.

Facebook

Partnership announced on September 16th with UK blood services to help top up the blood donation pipeline, will allow those aged 18 to 65 to sign up to receive updates on Facebook.

Facebook's new blood donation feature about giving blood, get notified about opportunities to donate at local blood donation centres and invite friends to donate.

Shared Learning Event - UK Blood services

A session was held to showcase the learning and sharing of good practice with colleagues across the UK following the secondment of a member of the Scottish Blood Transfusion Service to WBS as Head of WBS planning, logistics and resourcing team for 11 months. This exercise was supported by WBS and SNBTS as a knowledge

exchange and this was sustained through the Covid outbreak. The session enabled the development for the individual and the benefit for WBS and SNBTS to be shared by senior staff.

Exceptions

Delivery of the sufficient supply of blood to hospitals throughout Wales within a COVID environment is our key focus within the service, alongside the health and wellbeing of the donors and our staff.

This current staffing arrangements for collection services is and has been particularly complex and challenging during COVID and has been further compounded by 11 previously shielding collection staff being are unable to return to their core roles.

When combining this with a current vacancy factor as of September 30th of approx. 8 staff (6 registered nurses and 2 clinic collection staff), with an additional 7 staff on sickness absence/maternity leave, resourcing this service to meet hospital demand has been a particular challenge for the service. (Approximate 25% of workforce unavailable at any one time).

In addition newly trained staff have started in late September to support provision of a newly developed service known as plasmapheresis. Whilst this helps boost numbers on clinics, the training of staff by the collection workforce adds to their workload pressures due to their training needs.

Key mitigation has included recruitment of long term agency staff to support COVID related activities on collection clinics including triage of donors on arrival and undertaking enhanced control of infection measures.

In addition, teams are supplemented by part time Medical Laboratory Assistant staff from laboratories to support phlebotomy documentation duties to support collection staff on venepuncture and screening duties and the on board.

This issue is considered daily from a service provision perspective to ensure the safety and quality of the blood products collected, whilst also ensuring staff and well being are paramount in our thinking.



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Appendix 1

Welsh Blood Service Monthly Report

September 2020



Gwasanaeth Gwaed Cymru
Welsh Blood Service

- All clinical demand was met with overall stock position of red cells was 2347 at the end of September.
- All stock groups were maintained above 3 days.
- All clinical demand for platelets was met.
- Whole blood collection efficiency is below the target for the sixth consecutive month as a consequence of the ongoing need to increase resource requirements due to COVID 19, which has resulted in additional staffing being sent out per team to man a newly added triage point and to support the introduction of social distancing and PPE. this is likely to continue whilst COVID 19 is present in the community
- Manufacturing productivity continues to remain below target, as the result of decreased collections due to COVID 19 and increased staffing due to partial implementation of the ambient overnight hold staffing model.
- Time expired red cells was below 1% target due to changes in issuing practice to issue oldest units first (rather than a range of shelf life) due to change in demand from hospitals as a result of COVID
- Platelet expiry increased in September - expiry followed by increased production to cover the bank holiday at the end of August and in the third week following reduced demand.
- 90% of quality incidents closed within the required 30 days. This is just below the target position. This indicates a 10% improvement in performance from the previous month.
- No Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in September .
- 1 formal concerns requiring a formal response in 30 days was received in September
- All concerns were acknowledge within 2 working days of receipt, in line with target.
- Overall donor satisfaction continued to exceed target position at 96%.



9 Key Performance Indicators were above the previous month's performance.



6 Key Performance Indicators remained the same as the previous month's performance, however 5 achieved target.



6 Key Performance Indicators were down on the previous month's performance, however 4 achieved target.

3 of the 4 Quarterly (July - Sept) targets reported this month achieved target



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Reference Table

Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs manufactured as a % of the number of issues to hospitals (% Red Cell Demand Met)	100%	Monthly	Local
Number of bags of platelets manufactured as a % of the number of issues to hospitals (% Platelet Demand Met)	100%	Monthly	Local
Number of Confirmatory Tests (CTs) requested and bled as a % of the total CTs requested (Confirmatory Tests Bled)	65%	Monthly	Local
Number of Stem Cell Collections	80	Annual	Local
Number of antenatal patient results provided to customer hospitals within 3 working days from receipt of sample (Antenatal Turnaround Times)	90%	Monthly	Local
Number of samples referred for red cell reference serology work ups provided to customer hospitals within 2 working days. (Reference Serology Turnaround Times)	80%	Monthly	Local
% of Quality Incident Records (recorded in DATIX), closed within 30 days over a rolling 3 month period	90%	Rolling	Local
Number of critical non-conformances through external audits or inspections	0	Annual	Local
Number of Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines and Healthcare products Regulatory Agency (MHRA)	0	Annual	Local
Number of whole blood donations that are collected on session which are below the minimum viable volume, as a % of the total number of whole blood donations collected (% Part Bags)	3%	Monthly	Local
Number of donors where venepuncture is attempted to be performed on but no blood enters the bag, as a % of the number of donors who have reached the donation chair (% Unsuccessful Venepuncture)	2%	Monthly	Local
The number of blood components (weighted) collected per Standardised FTE (Blood Collection Efficiency)	1.25 WTE	Monthly	Local
Number of components manufactured per Standardised FTE. (Manufacturing Efficiency)	392	Monthly	Local
Number of platelets which have time expired as a % of the total number of platelets manufactured (Time Expired Platelets)	10%	Monthly	Local
Number of RBC units which become non-viable during the manufacturing process which could have been avoided, as a % of the number of complete whole blood donations (Controllable Manufacturing Losses)	0.5%	Monthly	Local
Number of bags of RBC, including Paediatric bags, which have time expired as a % of the total number of RBC bags manufactured (Time Expired Red Cells)	1%	Monthly	Local
Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied with their overall donation experience after they have been registered on clinic to donate (Donor Satisfaction)	71%	Monthly	Local
Number of 'formal' and 'informal' concerns received from blood donors	~	~	~
% of 'formal' concerns received and treated under 'Putting things Right Regulations within 30 working days	100%	Monthly	National
% of all concerns (formal and informal) acknowledged within 2 working days as required by the 'Putting things Right' Regulations	100%	Monthly	National
Number of new Whole Blood Donors recruited to the donor panel	2,750	Quarterly	Local
Number of new Apheresis Donors recruited to the donor panel	14	Quarterly	Local
Number of Deceased Donor Typing / Cross Matching reported within given period	80%	Quarterly	Local
Number of Anti D & -c Quantitation patient results provided to customer hospitals within 5 working days	90%	Quarterly	Local



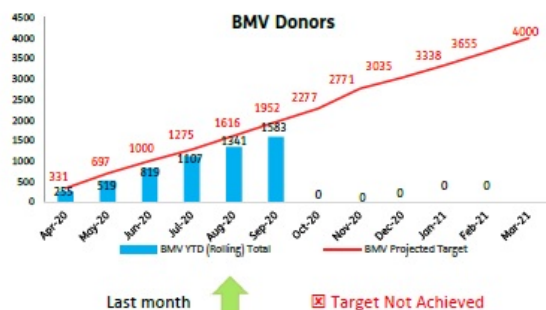
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Monthly Reporting

Equitable and Timely Access to Services

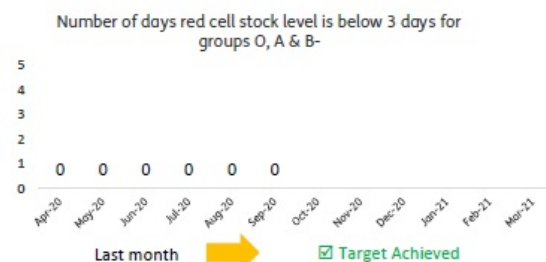
Sep-20



Annual Target: 4000		
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 242 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in September.	<p>Develop a new donor recruitment and retention strategy for the WBMDR aligned with the development of the revised WBS strategic intent.</p> <p>The new Donor Recruitment & Retention Strategy will be informed by:</p> <ul style="list-style-type: none"> - a review of the existing donor panel to assess the required growth; - a review of the outcomes of the new bone marrow pilot recruitment to provide proof of concept and operational readiness for a recruitment strategy that is not solely dependent on blood-donors. 	TBC - original deadlines delayed due to COVID. Task and Finish group has been established to take forward recruitment of non blood donors

Safe and Reliable Service

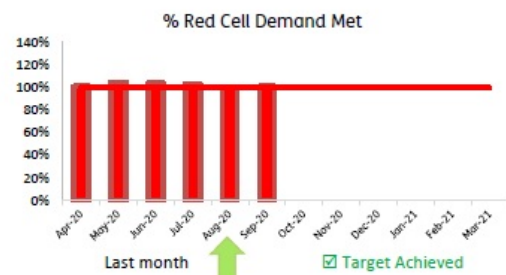
Sep-20



Monthly Target: 0		
What are the reasons for performance?	Action(s) being taken to improve performance	By When
All stock groups were maintained above 3 days. Stock levels are robust. Effective collaboration between the Collections and Laboratory teams within the Supply Chain supported the maintenance of robust stock levels.	Daily Resilience meetings are held in a collaboration of blood collection and manufacturing teams; this forum facilitates operational actions in response to challenges in maintaining adequate stock levels in order to minimise blood shortages. In addition, the Demand Planning Leadership Group meet on a weekly basis to monitor and review performance.	Business as Usual

Safe and Reliable service

Sep-20

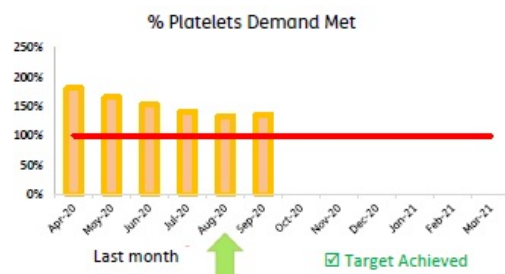


Monthly Target: 100%		
What are the reasons for performance?	Action(s) being taken to improve performance	By When
All demand for red cells was met. Stock levels remain robust across the blood groups. This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs. Pressure is being placed on stocks as a result in difficulties in collecting sufficient donations due to Covid-19 restrictions in collections.	Daily Resilience meetings are held in a collaboration of blood collection and manufacturing teams; this forum facilitates operational actions in response to challenges in maintaining adequate stock levels in order to minimise blood shortages. In addition, the Demand Planning Leadership Group meet on a weekly basis to monitor and review performance.	Business as Usual



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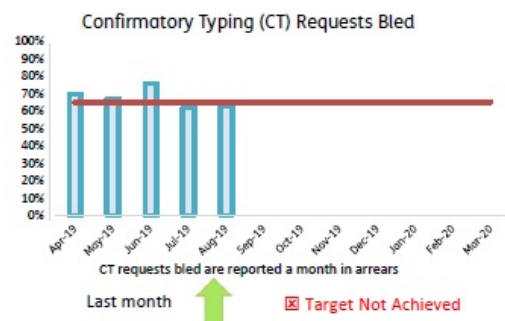
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Safe and Reliable service

Sep-20

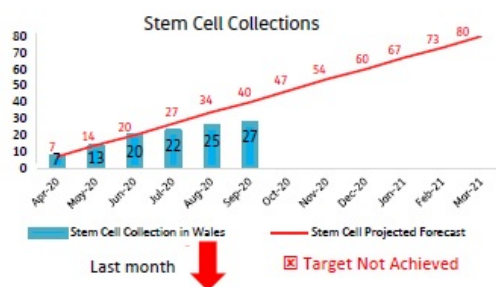
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
<p>All clinical demand for platelets was met.</p> <p>This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs.</p>		TBC Currently on hold due to other priorities as a result of COVID



Safe and Reliable service

Sep-20

Monthly Target: 65%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
<p>The number of CT requests for August was 32 (september not available):</p> <ul style="list-style-type: none"> - 20 donors were bled (63%) (0 cancellation, 4 failed medical or medical suspension) - 72% of samples were bled within 7 days - 91% of requests were completed within 14 days. (Industry KPI's are 50% and 80% respectively) - 84% of donors contacted 	<p>We have an ongoing system to keep donor details up to date and will continue to review all cancellations to apply learning to future practice wherever possible.</p> <p>We are engaging with stakeholders to improve understanding around turnaround times for donor requests and improve transplantation options for patients.</p>	Business as Usual



Safe and Reliable service

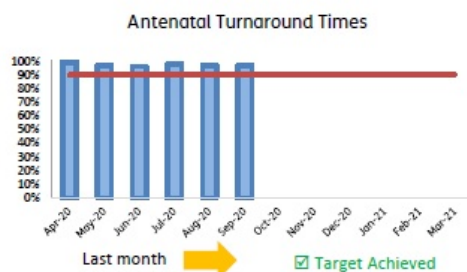
Sep-20

Annual Target: 80	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
<p>There were 2 Stem Cell Collections in September with YTD collections below target position.</p> <p>1x PBL Collected</p> <p>1 x Cancellations at work up stage.</p>	<p>Define and agree future strategy for Stem Cell collection as part of wider review of future strategy for the WBMDR.</p>	TBC delayed due to COVID but will form part of the Collection Centre review



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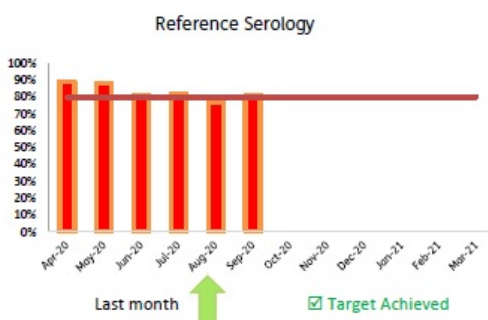
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Safe and Reliable service

Sep-20

Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turnaround times for routine Antenatal tests in September remained above target at 97%. Continued monitoring and active management is in place.	Continuation of existing processes which are maintaining high performance against current target.	Business as Usual



Safe and Reliable service

Sep-20

Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turnaround times for specialist referrals in September back on target at 81%. Workload returning to high levels (227 hospital patient referrals compared to average of 219 in 2019). All compatibility testing (>52% of referrals) completed to required time/date (which remains RCI priority).	A review of complex patient referrals will be undertaken as part of a laboratory modernisation project which is currently being scoped. This will be supported by a benchmarking exercise to review current turnaround time KPIs with UK counterparts. The laboratory modernisation programme has been suspended due to COVID. It is anticipated this will recommence early Autumn 2020	March 2021



Safe and Reliable service

Sep-20

Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Performance in September has met the target position, with 90% of quality incidents closed within the required 30 days. This indicates a 10% improvement in performance from the previous month. The number of incidents reported in the three month rolling period has increased (90 reports); 9 were not closed within this period, compared with 16 in the previous reporting period.	The agreed SMT action plan will remain in place to ensure that the improved performance is sustained. As part of the WBS response to the recent MHRA inspection findings, a root cause analysis exercise is being undertaken to determine reasons for reports being closed outside of the expected 30 day timeframe. The outcome of the investigation will be used to inform the corrective and preventive action required to improve performance against the 30 day target.	Continue with close monitoring



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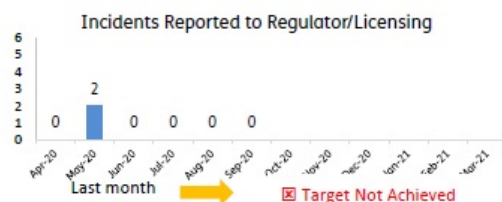
Sep-20



Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
UKAS undertook a routine surveillance inspection of H&I NEQAS against ISO standard 17043 during September. The outcome was one mandatory finding, to do with the management of persistent poor performance by participants in each EQA scheme, and 2 recommendations.	The findings of the UKAS inspection have been managed by providing a formal definition of persistent poor performance (PPP) for each scheme and performing a retrospective audit of PPP by UK labs. The two recommendations have also been addressed. Evidence for completion of action to address the mandatory finding has been submitted to UKAS, prior to the due date of 11th October 2020.	No further action required. MHRA action plan being managed as BAU.

Safe and Reliable service

Sep-20



Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
No Serious Adverse Events (SAE) were reported to the regulator or licensing authorities in September.	None required.	N/A

Spending Every Pound Well

Sep-20



Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The overall Part Bag rate for September 2020 remains within the 3.0% tolerance at 2.35% of donors who donated.	Ongoing work to maintain the part bag rate under tolerance threshold include (but is not limited to) the following: - Ongoing cycle of Points Of Care Audit	Business as Usual



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Last month

Target Achieved

The overall Part Bag figure gives general reassurance that this is not an area of concern. The breakdown of reasons for part bags for September 2020 are as follows:

Haematoma 12%
Donor Discomfort 3%
Poor Access 17%
Donor Request 2%
Late Info 1%
VVR 7%
Needle Placement 24%
Needle Displaced 2%
Clot in Needle 29%

Consideration must be given in future development of this measurement to the value of splitting into 'targetted' and 'other' groups

- Review of Audit findings and implementation of associated action plans

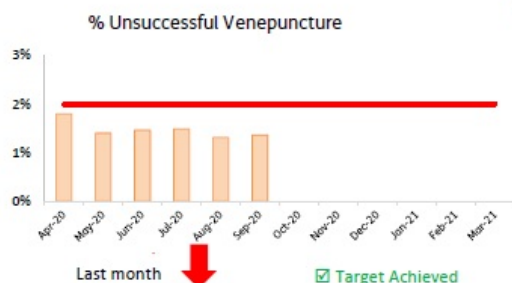
- Work with clinical teams with trend of exceedance of tolerance levels to determine cause and implement action plan

The factors that comprise the 'reasons for part bags' will continue to be monitored on an individual team and collective basis.

Business as Usual

Business as Usual

Business as Usual



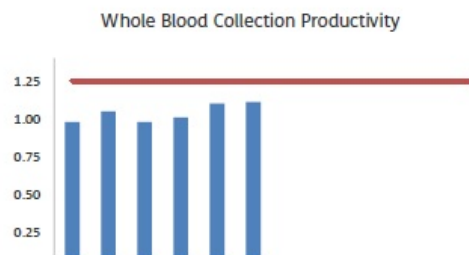
Last month

Target Achieved

Spending Every Pound Well

Sep-20

Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The overall Failed Venepuncture (FVP) rate in September 2020 successfully remained within the tolerance threshold at 1.36% of donors where a donation was attempted	Monitoring of FVP rates by team continues.	Business as Usual



Whole Blood Collection Productivity

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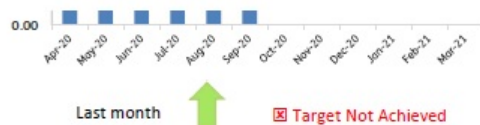
Sep-20

Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Collection efficiency is below the target of 1.25 for the sixth consecutive month as a consequence of the ongoing need to increase resource requirements due to COVID 19, which has resulted in additional staffing being sent out per team to man a newly added triage point, and to support the introduction of social distancing and PPE. Depending on the number of chairs put out, this could see an increase of up to 3 staff per team. This is likely to continue for the long term while COVID 19 is	The changes which were due to be brought in under the Blood Supply Chain 2020 have been put on hold during the COVID 19 pandemic.	March 2021



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present within the community. However a small improvement has been seen due increase in collections to meet demand and this has been sustained improvement for the past 3 months.

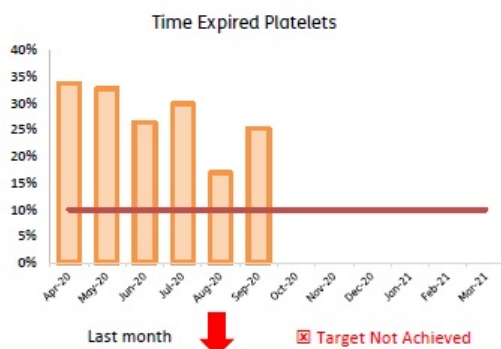
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Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
Production efficiency continues to remain below the target. The principle influences on this are lower collections and increased staffing in line with recruitment to ambient overnight hold.	Target to be reviewed in line with processing / staff changes as part of the Blood Supply Chain 2020 initiative.	BSC2020 put on hold due to COVID pandemic. Initial meeting recommended October 2020.

Spending Every Pound Well

Sep-20



Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Platelet expiry increased in September - expiry followed by increased production to cover the bank holiday at the end of August and in the third week following reduced demand. Overall wastage was down compared to previous months (except August) but production has also been reduced so the % wastage increased.	Further planned reductions in platelet production will continue.	ongoing

Spending Every Pound Well

Sep-20

2.0% Controllable Manufacturing Losses

Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



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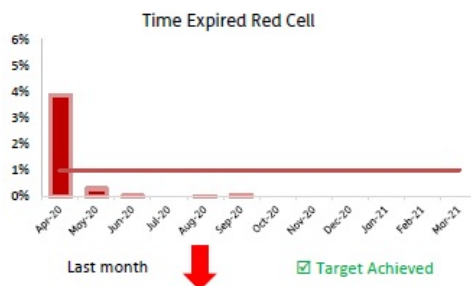
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The controllable red cell losses were : Incorrect Storage : 1 Heat Seal Failure : 1 Heat Seal Failure - air in packs (collections) : 1 Poor Packing : 1 Operator Error Blood Press : 1	Local reporting and management of incidents where they occur for monitoring of losses and lessons learnt.	Business as Usual
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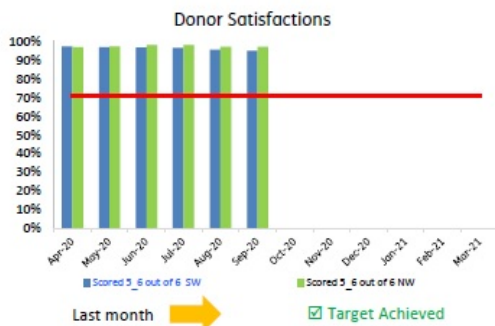
Sep-20



Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Time expired red cells are below the target of 1%.	Monitoring continues	Business as usual

First Class Donor Experience

Sep-20



Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Overall donor satisfaction continued to exceed target at 95.7%. In total there were 1,371 respondents, who had made a full donation, that shared their donation experience, 331 were from North Wales and 1,003 were from South Wales (where location was able to be defined).	Findings to be reported to management at Collections OSG meeting for actions from individual teams.	Business as usual

First Class Donor Experience

Sep-20

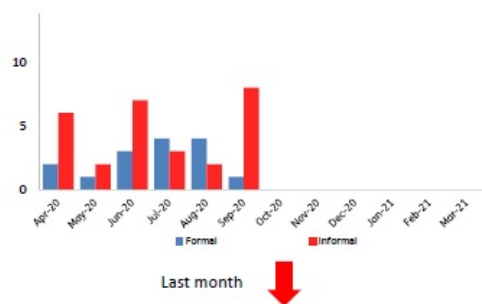
Number of Concerns Received

Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In September a total of 7141 donors were registered at Velindre University NHS Trust.	All concerns have been investigated and lessons learnt	Business as usual



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clinic. A total of 9 concerns (0.13%) were reported within this period with 8 being managed as Early Resolution (ER) within 2 working days and 1 formal complaint because of donor request.

Reasons for concerns during this period include:

- Wearing of face mask/covering on session when exempt
- Late attendance at clinic
- Not enough information about Covid 19 in text/on website
- Staff parking over driveway
- Temperature check on clinic
- Deferred at screening

identified and actioned as appropriate.

The 1 formal complaint was as a result of donors request. A full review of current SOP COL-027 (Triage Questions) has been undertaken, measures are in place to update for clarity. Text message reminders now have covid 19 information, a full review of text messaging reminder service. Process changed to now reflect covid 19 updated/information. A more focused approach has been adopted, being very clear on timeline restriction. Awareness raised with staff involved in contacting donors of this requirement and an improvement has been seen this month in terms of appointed staff attempting to contact much sooner.

First Class Donor Experience

Sep-20



Monthly Target: 100%		SMT Lead: Alan Prosser	
What are the reasons for performance?		Action(s) being taken to improve performance	By When
1 formal concern requiring formal response in 30 days received in September 2020.		Continue to monitor 30 day response compliance.	Business as Usual

First Class Donor Experience

Sep-20

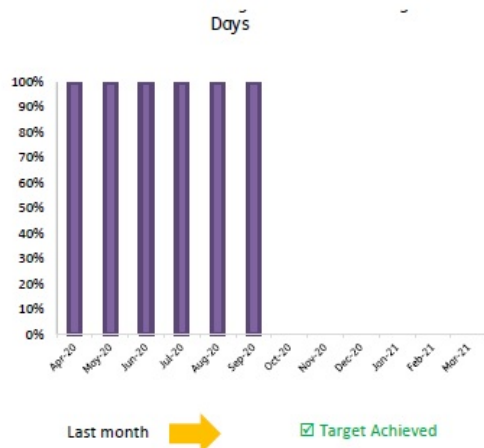
% Concerns Acknowledged within 2 Working

Monthly Target: 100%		SMT Lead: Alan Prosser	
What are the reasons for performance?		Action(s) being taken to improve performance	By When



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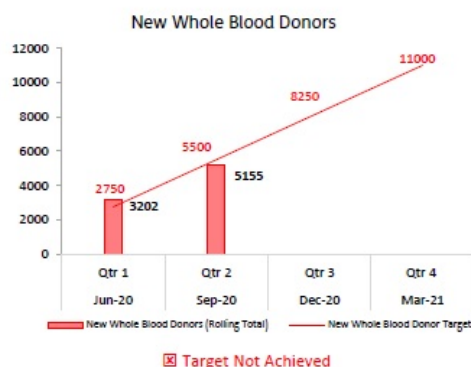


<p>100% compliance- All concerns were acknowledged within 2 working days of receipt. The formal complaint due to timeline was acknowledged within 2 working days.</p> <p>When considering this factor it has become apparent that there are different ways of viewing and thus measuring compliance against it. As described above, we are experiencing some areas of non-compliance against timeline but this is not reflected here using the current method of assessment. It may be useful, going forward, to re-define this factor to ensure we have clear visibility and so are able to identify areas that may require improvement.</p>	<p>Continue to closely monitor concern management timescales reinforced within training package.</p>	<p>ongoing</p>
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Quarterly Reporting

Equitable and Timely Access to Services

Sep-20



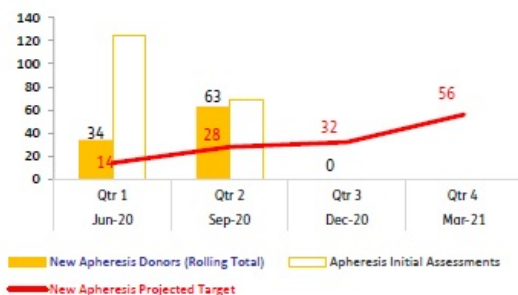
Quarterly Target: 2750	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
582 new donors completed a donation in September. While support from new donors remains strong, limited capacity at donation sessions across Wales has meant fewer opportunities for new donors to donate.		N/A



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New Apheresis Donors

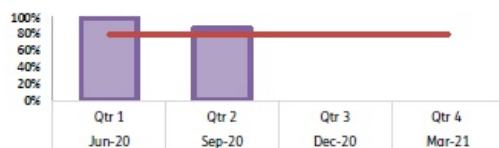


☑ Target Achieved

Quarterly Target: 14		SMT Lead: Jayne Davey
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 6 new apheresis donors in September 2020.	Continue to recruit new apheresis donors.	N/A

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Turnaround Times (Deceased Donor Typing/Crossmatching)



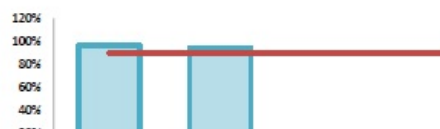
☑ Target Achieved

Sep-20

Quarterly Target: 80%		SMT Lead: Tracey Rees
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turnaround times were above target at 87%. Crossmatching has resumed following the pause to transplantation during lockdown. Numbers have returned to normal levels.	Continued monitoring and active management is in place.	TBC delayed due to COVID but will form part of the Collection Centre review

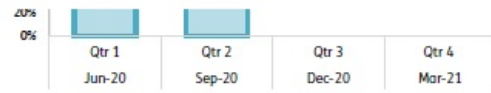
Safe and Reliable service

Anti D & -c Quantitation



Sep-20

Quarterly Target: 90%		SMT Lead: Tracey Rees
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turnaround times for September at 95%	Continued monitoring and active management is in place.	Business as Usual



☑ Target Achieved

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Appendix 2

Attachment 1: Assessment against Welsh Government guidance 'An Operational Guide for the Safe Return of Healthcare Environments to Routine Arrangements Following the Initial Covid-19 Response'

COMMUNICATION	
Information should be clearly communicated to patients and visitors prior to arrival at the hospital or healthcare facility.	
Clear information to be provided on the Health Boards website regarding operational changes to address COVID-19	Currently developing information which will be to WBS internet site
<p>Clear information to be provided on appointment letters to Patients attending for outpatient clinics or elective procedure regarding COVID-19 operational changes.</p> <ul style="list-style-type: none"> • Social distancing requirements • Patient only attendance (with carer support) • Site Entry • Car parking arrangements • Building entry points • One way systems within the building • Facilities for beverages • Hospital staff will be wearing PPE • Any specific expectations of them due to the nature of the appointment 	<p>Donors are contacted by telephone or text and given a time slot to attend their donation session. Walk-in appointments are currently suspended.</p> <p>A link will be added to the text donors receive to direct them to the internet site and the detailed guidance on what to expect in clinic including social distancing arrangements and staff wearing PPE.</p> <p>Donor also undergo a telephone triage prior to attending.</p> <p>As clinics are in currently closed premises belonging to the independent sector, there are no facilities available for hot beverages to be purchased.</p> <p>Car parking arrangements and building entry points will differ by venue.</p>

Appointment times should be clearly stated, with the earliest arrival time clearly indicated. This is intended to maintain social distancing in waiting areas and avoid large numbers arriving at similar times.	Donors receive a text, email or call with their appointment time
Consideration to be given for separate entry points for COVID-19 patients and staff.	N/A
Consideration to be given to locating COVID-19 patients within clearly identifiable separate areas of the building.	N/A
Staff should be dedicated to COVID-19 patients and should not mix with staff from other departments within the hospital.	N/A

SIGNAGE	
Signage should be clear and obvious	
Signage regarding COVID-19 should be clear and obvious at the entry to the hospital / health facility site. This should be clear on all signage whether arriving by car, public transport or on foot. Clear signage should state the main COVID-19 procedures such as large pictorials indicating the 2 metre social distancing requirement, together with	<p>Single entry points to buildings for majority of staff and donors.</p> <p>Instructional signage in place.</p> <p>Guidance on social distancing including 2m space, one person in lift/stairs in place.</p> <p>Ongoing review</p>

the importance of regular hand washing / hand sanitisation.	
Clear pictorial signage at the entry to the building indicating the location of the isolated COVID-19 areas, together with pictorial directions on how to navigate the building safely	N/A
Consideration should be given to the use of coloured directional arrows located on the floor or walls ensuring that it is clear and obvious how patients and visitors should navigate the building.	Signage in place to identify how buildings should be navigated
All signage to be bi-lingual and follow the guidance within "WAYFINDING" effective wayfinding and signing systems – guidance for healthcare facilities. Available from the NWSSP-SES website.	Signage is bi-lingual. This needs to be reviewed against the WAYFINDING guidance.
SOCIAL DISTANCING Social distancing of 2 metres must be maintained, including while arriving at and departing from hospitals and healthcare facilities including navigating between departments within the building	
Social distancing must be observed within hospitals and healthcare facilities. Patients, visitors and staff must observe the 2metre distancing rule.	<p>Assessments complete for all sites/offices/communal areas reviewing 2m spacing.</p> <p>Tables and chairs in communal areas have been positioned with 2m spacing.</p>

Consideration should be given to providing 2 metre markers located on the floor indicating the 2metre distance.	purchased and in place
Consideration should be given to physical separation within hospital corridors to ensure patients, visitors and staff travelling in opposite directions are kept separate. This could be provided by a clear screen material. This can only be considered in major hospitals where main hospital corridors are wide enough to all physical separation to be provided.	N/A
Lifts should be used by single occupants, if possible. Otherwise clear demarcation areas should be located on the floor clearly indicating where patients or visitors should stand.	There are 2 lifts on WBS Talbot Green site. Signs have been put up both inside and outside the lift advising of one person maximum occupancy level
Clear travelling protocol should be developed for the use of stairs. Patients and visitors should not cross on the stair itself but wait on landings allowing as much clear distance as possible for passing.	There are two sets of stairs in WBS Talbot Green Site. Signs are displayed at both the top and bottom of the staircase advising people to 'stop, think and give way' advising of one person on the stairs at one time
Consideration to be given to deploy Volunteers, porters and security staff throughout circulation routes to re-inforce the social distancing message.	<p>All staff have been reminded of their responsibility to challenge appropriately.</p> <p>Additional staff have not been used as they would increase the risks around social distancing given the aforementioned estate restrictions.</p>

	<p>Regular information is provided in the daily email bulletin and local bulletin on social distancing message.</p> <p>Video has been produced to advise of social distancing measures in place.</p>
INFECTION CONTROL Infection Control instructions should be clear and obvious	
Using signs and posters to build awareness of good handwashing technique, the need to increase handwashing frequency, avoid touching your face and to cough or sneeze into a tissue which is binned safely, or into your arm if a tissue is not available.	Increase in signage and posters displaying reminding individuals to frequently wash their hands.
Hand sanitation facilities should be provided prior to entry into the building, within entrance lobbies or immediately on entering the building.	Hand sanitation stations are in place across the site including all entrances/exit points.
Hand sanitation facilities to be provided at regular points throughout corridors but especially at entry and exit from departments.	<p>Hand sanitation stations are in place across the site including all entrances/exit points.</p> <p>Each department has wipes and hand sanitiser provided. This is monitored on a weekly basis.</p> <p>Hand sanitiser and wipes are available in communal areas include meeting rooms and advisory signs on their usage</p> <p>Additional dispensers are being purchased to put up at the entrance to the communal areas and individual departments</p>

Regular cleaning should be undertaken especially of frequently touched surfaces such as door handles, support rails etc.	Enhanced cleaning contract in place which includes: daily presence on sites during working hours, cleaning of frequently touched surfaces such as support rails, door handles, reception screen, laboratories, kitchen facilities
Frequent cleaning of work areas and equipment between uses, using your usual cleaning products.	<p>Antibacterial wipes and hand sanitiser are available in each department and staff are advised to clean desks and equipment before use.</p> <p>Antibacterial wipes and hand sanitiser are available in communal and meeting areas and signage in place advising their use to clean desk/meeting tables/equipment before use.</p>
Frequent cleaning of objects and surfaces that are touched regularly, such as door handles and keyboards, and making sure there are adequate disposal arrangements.	<p>Antibacterial wipes and hand sanitiser are available in each department and staff are advised to clean desks and equipment before use.</p> <p>Antibacterial wipes and hand sanitiser are available in communal and meeting areas and signage in place advising their use to clean desk/meeting tables/equipment before use.</p> <p>Enhanced cleaning contract in place which includes: daily presence on sites during working hours, cleaning of frequently touched surfaces such as support rails, door handles, reception screen, laboratories, kitchen facilities</p>
Clearing workspaces and removing waste and belongings from the work area at the end of a shift.	All staff reminded to clear workspaces etc via regular communications.

Toilets should be accessed by one person at a time. This should be observed for toilets with more than one W.C. or urinal.	Signage in place to stating 'one in one out'
GENERAL AREAS Reception desks and Waiting Areas	
Install transparent screens at reception desks to protect reception staff.	All reception areas have Perspex screens in place and any associated risk assessment.
Introduce a strict appointment system with earliest allowable arrival times to enable the control of numbers within the waiting area.	Donors are given a timeslot to attend clinic.
Movable seating to be re-arranged to ensure 2 metre social distancing is in place. Fixed seating to be taped off to prevent seats being used.	All seating across WBS site assessed according to distancing and 2m spacing. Excess chairs have been moved to storage
Directional signage located on floors to be use to ensure circulation promotes social distancing	Mitigation in relation to risk assessment. Floor markers in place to facilitate 2m distancing.
COVID-19 infection control messages should be clear and visible wherever seated.	Signage has been put up in the communal areas indicating the need to maintain 2m social distancing spacing.
Hand sanitisers should be provided at regular intervals, especially outside toilets, baby feeding and baby changing facilities. This will allow door handles to be wiped on entry and exit.	Hand sanitation stations are in place across the site including all entrances.

STAFF AREAS Staff areas / break out areas / rest areas / restaurant areas	
Staggering break times to reduce pressure on break rooms or places to eat.	<p>Laboratory staff are unable to eat/drink within their work environment and need to make use of the communal break facilities. Where possible consideration has been given to more flexibility around break times. Additional space has been open between 12-1.45pm and additional kitchen facilities have been made available.</p> <p>Staff who do not have fixed breaks or are able to use other areas are asked to be mindful of when they choose to use the kitchen facilities.</p>
Using safe outdoor areas for breaks.	Tables and chairs purchased and in place for outdoor break areas.
Reconfiguring seating and tables to maintain spacing and reduce face-to-face interactions.	Seating and tables within communal areas assessed and changes implemented to adhere to 2m spacing restrictions.
Tables to be physically marked with yellow tape to indicate seating areas which are to be left vacant. Seating to be removed. Clear directional signage on the floor to direct safe movement.	Seating and tables within communal areas assessed and changes implemented to adhere to 2m spacing restrictions. Tape has been placed on the floor in break area to clearly mark where tables and chairs need to remain.
Encourage patients, visitors and staff to bring their own food. This does not apply to inpatients.	No catering facilities on site
Regulating use of locker rooms, changing areas and other facility areas to reduce concurrent usage.	Social distancing assessment complete. Appropriate signage and messaging in place. Communication to staff requesting removal of personal items from common areas.

Encouraging storage of personal items and clothing in personal storage spaces, for example, lockers and during shifts.	Appropriate signage and messaging in place. Communication to staff requesting removal of personal items from common areas.
Provide appropriate signage in common areas to restrict access when social distancing is not possible / practical	Signage in place.
Where shower and changing facilities are required, setting clear use and cleaning guidance for showers, lockers and changing rooms to ensure they are kept clean and clear of personal items and that social distancing is achieved as much as possible.	Risk assessment complete. Single unisex shower cubicle now in place. Signage in place

OFFICE AREAS

Administration

Review layouts and processes to allow people to work further apart from each other.	<p>A comprehensive social distancing review of all departments including labs and office space has been completed.</p> <p>Where social distancing is difficult, alternative measures have been put in place e.g. PPE, screens.</p> <p>Social distancing assessments have supported changes put in place from the outset including:</p> <ul style="list-style-type: none"> • Supporting home working where possible • Introduction of rotas
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	<ul style="list-style-type: none"> • Change in shift patterns • Maximum number of donor chairs in clinics.
Using floor tape or paint (subject to Health & Safety recommendations) to mark areas to help workers keep to a 2m distance.	2m floor markings used in appropriate environments, including laboratories and in communal areas.
Only where it is not possible to move workstations further apart, arranging people to work side by side or facing a way from each other rather than face-to-face.	Back to back working is in place in some areas, desk space has been reallocated and supports staff at alternative desks where possible which allows for 2m distancing. Where this is not possible e.g. labs, additional risk assessment has been undertaken and alternative support has been put in place e.g. PPE.
Only where it is not possible to move workstations further apart, using screens to separate people from each other.	Social distancing assessments completed of all departments identifying space requirements and location of furniture. Distancing of staff across work stations currently possible due to number of staff working from home/on rotas. As business as usual returns, core staff may be required on site, which means further assessments and mitigation may be required.
Managing occupancy levels to enable social distancing.	Social distancing assessment used to determine safe occupancy levels and furniture/staff spacing for all site environments; signage installed and measures to support distancing.
Avoiding use of hot desks and spaces and, where not possible, for example, call centres or training facilities, cleaning workstations between different occupants including shared equipment.	This is not possible in some areas in WBS e.g. DCC call centre and Business systems. This will be an increasing issues as service return to BAU and staff are required on site for some of their working week. Antibacterial wipes and hand sanitiser have been provided and staff are required to clean their workstation between use.

Provide hand sanitisers at regular intervals within the office space

Hand sanitation stations are in place across the site including all entrances.

FIRE PROTECTION

Fire Alarm and Fire Escape following physical changes to the environment in response to COVID-19

Any physical changes to the environment must only be carried out following consultation with the Health Board fire officer, NWSSP-SES Authorising Engineer – Fire and the Fire Authority.

Trust fire safety adviser consulted and given opportunity to comment with regard to potential changes to buildings etc. by Estates Manager and Capital Planning Manager.

Where required, additional risk assessment and review of existing fire risk assessment undertaken.

Where appropriate, other parties would be consulted as per Building Regulations and Regulatory Reform as well as advice on WHTM 05 compliance

The fire alarm system and fire escape routes must maintain full integrity following any physical changes.

Trust fire safety adviser consulted and given opportunity to comment with regard to potential changes to buildings etc. by Estates Manager and Capital Planning Manager.



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Where required, additional risk assessment and review of existing fire risk assessment undertaken.

Where appropriate, other parties would be consulted as per Building Regulations and Regulatory Reform as well as advice on WHTM 05 compliance

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	26 th November 2020
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Laura Tolley, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING
ACRONYMS	

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Inaugural Strategic Development Committee held on 5th November 2020.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

<p>ALERT / ESCALATE</p>	<p>There were no items identified for Alert / Escalation to the Trust Board.</p>
<p>ADVISE</p>	<p>Strategic Development Committee Terms of Reference & Cycle of Business: The Committee endorsed the Terms of Reference & Cycle of Business for Trust Board approval.</p> <p>Trust Long Term Strategy – Outcomes from Engagement: The Committee were advised that work was being undertaken to refresh the Trust's Mission & Vision. The Committee were pleased to note engagement had taken place with colleagues across the organisation to determine the Trust draft goals which set out the direction of travel for the Trust until 2030.</p> <p>The Committee acknowledged that further engagement would be required and were made aware that the timeframe for the launch of the new suite of strategies needed flexibility due to the ongoing pandemic.</p> <p>The Committee recognised whilst the strategy work faced some challenges, it was vital to lead the work of the organisation and without it, the organisation could not deliver effectively on the significant change programmes currently ongoing within the Trust.</p> <p>TCS Programme – South East Wales Acute Oncology Business Case Update: The Committee received an update regarding the Acute Oncology Business Case and were pleased to note that the emphasis of the Acute Oncology Business case was to improve overall patient experience across south east Wales. The Committee were also encouraged to hear of the collaborative work being undertaken with other Health Boards across the region.</p> <p>The Committee noted that the full business case would be written in December 2020 and a request for funding would be for the 2021-22 financial year.</p> <p>Performance Framework Review – Update and Next Steps Presentation: The Committee were presented with an update on the Performance Management Framework and noted how this would be a fundamental change</p>



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	<p>in how the Trust was looking to operate as an organisation, therefore, emphasised the importance of communication and engagement regarding this.</p> <p>The Committee were informed that benchmarking opportunities would be explored, both inside and outside of Wales and were pleased to note that an important part of the performance framework was to ensure that the Trust Board received a Performance Management Framework report in a format that could be understood.</p>
ASSURE	<p>Trust Assurance Framework: The Committee were informed that the Trust Assurance Framework was a management tool for those responsible for strategic decisions.</p> <p>The Committee were advised for the framework to be developed, a series of dual workshops were held to create a view of strategic risks for the first time and to refresh the content of the Trust Strategic Framework.</p> <p>The Committee noted that the Trust Assurance Framework would focus on long term risks to the Trust Strategy.</p>
INFORM	<p>There were no items identified to inform the Trust Board.</p>
APPENDICES	

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	27.11.2020
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Katie Foward, TCS Programme Coordinator
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital
REPORT PURPOSE	FOR NOTING
ACRONYMS	
nVCC TCS WG	New Velindre Cancer Centre Transforming Cancer Services Welsh Government

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee at its Public meeting on the 12th November 2020.
- 1.2 This is not considered a full update on the Programme but a high level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

1.3 Key highlights from the meeting are reported in section 2.

1.4 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	
ADVISE	<p>TCS Programme Financial Report</p> <p>The Committee were advised that Projects 1&2 (Enabling Works and nVCC) have been notified that the funding request to Welsh Government (WG) has been granted. The £3,200,000 will cover the year spend to date and the agreed spends for the remainder of the financial year.</p> <p>A proportion of the allocation has been withheld in relation to spends following the agreement of the Outline Business Case (OBC). However, where necessary, WG have granted special permission for a single tranche of funding to be released from that OBC allocation in relation to works that have taken place week commencing the 9th November on Asda land to complete survey activities.</p> <p>The spend will be closely monitored by WG and any overage not spent on the agreed works will be required to be returned.</p>
ASSURE	<p>TCS Programme Risk Register</p> <p>The Committee noted work undertaken by the Programme Planner and Risk Advisor. The cover paper accompanying the register provides a summary breakdown of the changes made to each of the risks for audit purposes. The Programme risks are now under regular review with each of the Project Managers. All changes to the actions this month have been captured and there is a clear audit trail of all work undertaken. Work to establish the most appropriate risk owners for each risk is underway. There is work remaining to ensure risk action plans are robust and this will be undertaken with risk owners. A risk in relation to tree felling was highlighted. The Project Director advised that the timescales are under close management and advised that the public would be reassured that works would be undertaken in line with planning agreements.</p>
INFORM	<p>Communications and Engagement</p> <p>The Committee were advised that the focus has shifted to engagement on the clinical model. The key focus for engagement with internal and external stakeholders is now focusing on the review work being undertaken by the Nuffield Trust. Work is ongoing to develop the scope of Velindre Futures and engage with staff on how they can be involved with all clinical developments. The volume of correspondence remains high as do the number of Freedom of Information requests that the Trust are responding to. A response has</p>



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	<p>been provided in respect of the Petitions Committee request for further information. Communication will be carried out with key stakeholders over the forthcoming weeks in relation to the additional social media page for the TCS Programme.</p> <p>Nuffield Trust Advice Project – Progress Update The high level message from the Nuffield Trust is positive in that they are on track with their work and expected to produce a full report on time at the end of November.</p>
APPENDICES	Not Applicable

Trust Board

Transforming Cancer Services Communications and Engagement Update

DATE OF MEETING

26/11/20

PUBLIC OR PRIVATE REPORT

Public

IF PRIVATE PLEASE INDICATE REASON

Not Applicable – Public Report

PREPARED BY

NON GWILYM, ASSISTANT DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT

PRESENTED BY

LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE

EXECUTIVE SPONSOR APPROVED

LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE

REPORT PURPOSE

For noting

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

COMMITTEE OR GROUP

DATE

OUTCOME

TCS PROGRAMME BOARD

9/11/20

Noted

ACRONYMS

TCS

Transforming Cancer Services

TCAR

Temporary Construction Access Road

MS

Member of the Senedd

MP

Member of Parliament

VCC

Velindre Cancer Centre

nVCC

New Velindre Cancer Centre

VUNHST	Velindre University NHS Trust
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1. BACKGROUND

1. This paper provides the Board with an update on Programme communications and engagement since October 2020.
2. The Programme Board approved the TCS Programme Communications and Engagement strategy in December 2019. The strategy emphasises the importance of good one-to-one stakeholder engagement, building positive relationships and informing our patients, staff and communities of interest.
3. A high level Programme narrative was adopted to support the strategic alignment of the seven projects built around core messages:
 - Clinical outcomes for cancer patient in Wales compare unfavorably with other developed countries;
 - In future we will treat more patients and help more people live longer with cancer;
 - In future we will treat more patients closer to home;
 - We will invest in research, development and innovation to enable the delivery of high quality cancer services for the long-term.
4. To date, mainstream Programme communications has been delivered under the VCC brand and channels.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Over the reporting period we have focused our efforts on:

- supporting the development of the Velindre Futures Programme;
- responding to correspondence from a wide range of stakeholders;
- regular communications and engagement with staff (weekly and ad hoc);
- responding to the Freedom of Information requests;
- regular meetings and engagement with the local MS and MP;
- developing a new social media page for public discussion and engagement on service developments;
- supporting the development of a new patient engagement strategy;
- engaging with the media on requests;
- supporting the development of the design development process.

A rolling plan continues to be overseen by a Communications and Coordination Group, including Independent Members and members of the Executive Board.

Clinical model engagement

During the reporting period we have supported the Velindre Task and Finish groups to manage their communications. We are also supporting the development of the Velindre Futures programme to define and deliver its design needs, staff engagement plan and patient engagement plan.

The [Terms of Reference and related project page](#) for the Nuffield Trust independent advice project were published on Nuffield Trust's website on 6 October and was communicated to internal and external stakeholders on the same day. When asked, we have supported the promotion of engagement opportunities commissioned by the Nuffield Trust in support of their project.

Public and staff engagement

Since 30 September we have reduced the frequency of proactive nVCC messaging.

A public notice was issued on the VCC Facebook on 14 October reinforcing messages about the purpose and independence of the page and our expectations regarding language and behaviors of followers engaging in discussions.

The statement also heralded the establishment of a new page to inform and involve the public and patients in the development of future cancer services. This will provide all TCS and other potential VCC projects opportunities to pose questions and engage regularly with the public on the relevant issues. The page will be live before the end of November.

Senedd Petition

Petition 1: "Hold an Independent inquiry into the choice of site for the proposed new Velindre Cancer Centre"

Petition 2: "Support for the current proposed plans to build a new Velindre Cancer Centre, Cardiff, in any future inquiry"

Following its meeting on 16 September, the Senedd Petitions Committee requested the following information from VUNHST:

- a copy of the "to scale" footprint of the proposed development projected onto the Whitchurch hospital site.
- an explanation of the MIM model.
- a copy of the Barrett review.

- a series of questions about unscheduled care arrangements at VCC.
- the scope of the Nuffield Trust project.

Staff engagement

Ongoing engagement and communication with our staff remains of paramount importance to us and we continue to encourage open and honest discussion which is now further enabled by the launch of the Work in Confidence application.

Political stakeholders

Over the reporting period, further meetings have been held with the local Member of the Senedd and Member of Parliament and the Welsh Conservative Health Spokesperson.

Supporting planning requirements

During the reporting period, we have identified key messages and provided support to the planning team that supports the Enabling Works project in advance of the Cardiff Council's consideration of the Temporary Construction Access Road (TCAR) application.

Next Steps

For the next month, our priorities will be as follows:

- coordination of the VUNHST public and internal response to the Nuffield Trust report and recommendations, expected before the end of November;
- supporting the design development process;
- internal communications and engagement planning relating to the Velindre Futures Programme;
- establishing a new TCS/nVCC social media presence including monitoring and evaluation systems;
- establishing a new regular external stakeholder bulletin;
- ongoing staff engagement sessions and a second round of engagement sessions by the nVCC project Director, CEO and Chair progressing patient engagement plan with key partners.

Recommendation

The Board is asked to note the update.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the paper.

TRUST BOARD

HIGHLIGHT REPORT FROM THE ACADEMIC PARTNERSHIP BOARD

DATE OF MEETING	26 th November 2020
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Catherine Currier, Business Support Officer
PRESENTED BY	Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Scientists
REPORT PURPOSE	FOR NOTING

1. PURPOSE

This paper had been prepared to provide the Trust Board with details of the key issues considered by the Academic Partnership at its meeting on the 14th October 2020.

The Board is requested to **NOTE** the contents of the report and the developments to date.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	<ul style="list-style-type: none"> There were no items for alert or to escalate.
ADVISE	<ul style="list-style-type: none"> Due to the pandemic the inaugural Academic Partnership Board was held in two parts via Microsoft Teams. Both meetings were well attended by Trust and University partners and positive energy was noted at both meetings: <ul style="list-style-type: none"> Part A of the Academic Partnership Board was held on 22nd July 2020 and the highlight report was subsequently reported to the Board. Part B of the Academic Partnership Board was held on 14th October 2020. This meeting and provided Academic Partners to inform the Trust of their activities and collaborations. Feedback on joint work since the meeting on 22nd July 2020 was also provided. At the meeting on 14th October 2020 it was apparent that a lot of significant developments and collaborations had developed since the meeting held on the 22nd July 2020 meeting. The following are the key areas of work being progressed: <ul style="list-style-type: none"> 'Show and Tell' for Digital & Information Sessions with Swansea, University of Wales Trinity St David's and Cardiff Universities. Discussions on potential research projects with Swansea and Cardiff universities. The development of a Digital Degree Apprenticeship with the University of Wales Trinity St David's. Research Collaboration between the nVCC Project and Cardiff Business School. Work on embedding collaborative working within the Service Improvement process. The Academic Partnership Board Terms of Reference were approved at the 14th October 2020 meeting and have been submitted to Trust Board for final approval.
ASSURE	<ul style="list-style-type: none"> There was no items for assurance.
INFORM	<ul style="list-style-type: none"> There were no items for information.
APPENDICES	<p>NOT APPLICABLE</p>



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TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 30TH SEPTEMBER 2020 (M6)

DATE OF MEETING	26/11/2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report	
PREPARED BY	Steve Coliandris, Financial Planning & Reporting Manager	
PRESENTED BY	Mark Osland, Executive Director of Finance & Informatics	
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance & Informatics	
REPORT PURPOSE	FOR NOTING	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
ACRONYMS		
MMR	Monthly Monitoring Returns	

1. SITUATION/BACKGROUND

- 1.1 The attached report outlines the financial position and performance for the period to the end of September. It includes the expenditure position, performance against financial savings targets and highlights the financial risks and forecast for the financial year, outlining the actions required to deliver the IMTP financial plan for 2020-21.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

KPI Target	Unit	Current Month £000	Year to Date £000	Year End Forecast £000
Revenue (To ensure net operating costs do not exceed income)	Variance	30	10	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	310	3,513	5,938
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.6	97.1	95.0

2.2 Revenue Budget

Excluding the impact of costs directly associated with Covid, the overall revenue budget is broadly in line with expectations and we continue to forecast a breakeven position at the end of the financial year.

We are experiencing a number of cost pressures which have surfaced since the completion of the IMTP at the beginning of the year, but in line with normal budgetary control procedures these are being managed to ensure the delegated expenditure control limits are not exceeded.

Savings and income targets have been affected by Covid but these have been identified separately and the forecast outturn position is dependent upon these being funded by WG. Details of the financial implications of this and the rationale for the underachievement are being shared with WG each month.

2.3 Covid Expenditure

The overall gross expenditure directly associated with Covid is now forecast to be £8.2m. This includes Hospice funding of £3.1m which is passing through the Trust and is fully funded by WG. Also the Trust has received confirmation that it will be reimbursed for revenue expenditure associated with the Convalescent Plasmids project up to £1.153m and has also recently received payment of £257k for the additional pay costs that were incurred during quarter 1.

The gross forecast of £8.2m also incorporates estimated costs of £1m specifically to provide additional capacity to meet an expected increase in demand during the final months of the year. This has been further revised down from the previous forecasts due to the projected increase in treatment capacity requirements shifting from October to February/ March.

At the time of reporting, the unfunded element of our forecast Covid expenditure amounts to £3.7m

2.4 Reserves

The financial strategy for 2020-21 included withholding a small level of unallocated budget to be used in support of the Trust transformation and delivery agenda. During the year a number of decisions have been made by the Executive Management Team to allocate funding from this unallocated sum to support priority purposes.

The remaining recurrent and non recurrent unallocated budget is £88k and £77k respectively.

In addition to the unallocated budget and in accordance with standard practice the Trust maintains an Emergency reserve to accommodate any emergency or unforeseen circumstance that may arise in the year. **This reserve remains at £522k.**

2.5 Financial Risks

The main financial risk relates to full reimbursement of the additional expenditure incurred as a direct result of Covid.

2.6 Update on Contracting Arrangements with Commissioners

Due to the uncertainties associated with Covid 19 it has been agreed with our Commissioners that we will maintain a 'block contract' arrangement for the whole of the 2020/21 financial year. For Velindre this means that contracting income will be based on the 2019-20 outturn plus the agreed baseline uplifts until September.

2.7 Capital

There remains considerable uncertainty surrounding the Trust capital programme for the current financial year, primarily due to the absence of securing a formal budget allocation for the TCS programme and its consequential effect on the Trusts discretionary programme, together with a number of large schemes in the pipeline for which budget has also not yet been secured.

Performance against the current agreed All Wales budget allocations are generally on course to deliver as expected although some variances will occur. These have been highlighted to Welsh Government in a recent update provided on 15 September.

▪ **TCS**

The Trust remains in dialogue with Welsh Government regarding a budget allocation for projects 1 and 2 of the TCS programme with a current unfunded forecast requirement of **circa £3.3m**. In a recent meeting with WG we have been assured that this is acknowledged as a priority and Ministerial advice is being drafted. We are hopeful that a decision will be made very soon.

In the meantime we are having to rely on our discretionary capital budget to fund the on-going commitments which is now having a significant impact on our ability to deliver other urgent discretionary capital needs across the Trust.

▪ **Covid-19**

The Trust has received the majority of its funding request in relation to actual capital expenditure incurred which is directly associated with Covid. **This is circa £1m**. A future forecast of **an additional £535k of capital expenditure related to Covid** has recently been submitted to Welsh Government.

▪ **WG All Wales Capital Programme Update**

In addition to the request for additional capital to cover future Covid related costs, as identified above, on the 15th September the Trust also provided WG with an update on

other project funding which the Trust is seeking in the current year from the All Wales capital Programme. This amounted to **£2.6m** and covered the following projects.

VCC Fire Safety
VCC Ventilation
VCC Infrastructure
WBS HQ Infrastructure and Equipment.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of September 2020 is an underspend of £10k with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

- 4.1 Trust Board is asked to **NOTE** the contents of the September 2020 financial report and in particular:

- the financial performance to date, and the year-end forecast to achieve financial break-even which is based on the assumption that all Covid19 related costs are fully funded by WG.
- the TCS financial position as at the end of September attached as appendix 1.
- also the core Trust WG MMR as at the end of September attached as Appendix 2



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FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED SEPTEMBER 2020/21

**TRUST BOARD
26/11/2020**

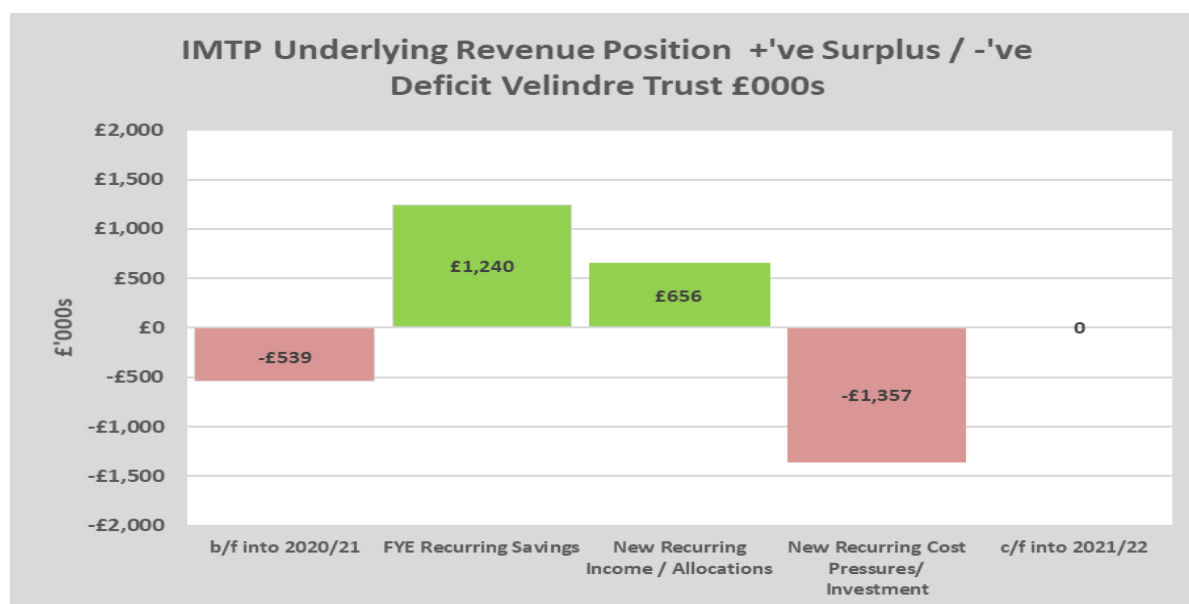
1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets and highlight the financial risks and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2020-21.

2. Background / Context

The Trust Financial Plan for 2020-21 was set within the following context.

- The Trust submitted a balanced Integrated Medium Term Plan (IMTP), covering the period 2020-21 to 2022-23 to the Welsh Government on 31 January 2020. The IMTP was submitted on the basis of delivering financial balance for each of the three years.
- For 2020-21 the IMTP included;
 - an underlying **deficit of £539k brought forward from 2019-20**
 - **new cost pressures/ Investment** in 20-21 of **£1,517k** (Recurring FYE effect £1,357k),
 - offset by **new recurring Income allocation of £656k**,
 - and **savings schemes of £1,400k**, (£1,240k FYE recurring), which can be further split between savings schemes £1,000k (£940k FYE recurring), and income generating schemes of £400k (£300k: FYE recurring).
- The Trust is expecting to fully eliminate the underlying position in line with the approved IMTP, partly through the utilisation of growth funding, and partly through internal savings in order to take a balanced position into 2021-22. **However in order achieve a balanced carry forward position the savings target set for 2020-21 must be achieved.**



Underlying Position +Deficit/(-Surplus) £000s	b/f Into 2020/21	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f Into 2021/22
Velindre NHS Trust	- 539	1240	656	- 1357	-

3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

KPI Target	Unit	Current Month £000	Year to Date £000	Year End Forecast £000
Revenue (To ensure net operating costs do not exceed income)	Variance	30	10	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	310	3,513	5,938
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.6	97.1	95.0

Performance against Planned Savings

Efficiency Savings /	Variance	(46)	(279)	0
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Revenue

The Trust has reported a **£30k** in-month underspend for September '20, with a cumulative position of **£10k** underspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at September 2020 is currently **£5,938k** for 2020-21. This represents all Wales Capital funding of £2,653, Discretionary funding of £1,850k and funding for Covid-19 of £1,435k.

The current cumulative spend against the programme as at the end of September is **£3,513k**, (which includes £1,172k of Covid-19 expenditure) with a forecasted spend of **£5,938k** to match the current CEL.

The forecast spend against Capital excludes the costs of the TCS programme which is currently assumed to be funded by WG, although the Trust has yet to receive this confirmation.

PSPP (Excluding Hosted Organisations)

During September '20 the Trust (core) achieved a compliance level of **96.6%** (July '20: 99.3%) of Non-NHS supplier invoices paid within the 30 day target, which gives a cumulative compliance figure of **97.1%** to the end of September compared to the target of 95%. The Trust continues to work with its staff and NWSSPP Accounts Payable to ensure prompt authorisation of invoices and receipting of goods.

Efficiency/ Savings

The Trust is currently forecasting a full year underachievement of **£(700)k** against the savings plans, £(279)k year to date, which is a direct result of Covid-19. The Trust is currently working to the assumption that any savings which are not achieved and are directly related to Covid-19 will be fully funded by WG.

4. Revenue Position

Cumulative				Forecast		
£(9,892) Underspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(74,647)	(74,163)	(485)	(145,743)	(144,920)	(823)
Pay	32,715	32,588	127	65,051	64,910	141
Non Pay	41,932	41,565	368	80,693	80,010	683
Total	0	(10)	10	0	(0)	0

The overall position against the profiled revenue budget to the end of September is an under spend of £10k, with an underachievement against income offset by an underspend on both Pay and Non pay. This is further analysed in the tables below.

The Trust continues to report a year end forecast breakeven position, however this is based on the assumption that all additional Covid-19 costs are fully reimbursed by WG.

4.1 Income Analysis

	Cumulative			Year End Forecast		
	£(485)k Underachievement			£(823)k underachievement		
Income Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Core Income - HB / WHSSC	33,395	33,393	(2)	70,000	70,000	0
Nice/ High Cost Drugs	19,689	19,689	0	34,902	34,902	0
WBS Wholesale Blood Products	5,427	5,433	6	12,361	12,361	0
WBS WTAIL	1,538	1,285	(253)	3,007	2,585	(422)
WBS Blood Components	118	91	(26)	385	183	(202)
Home Care Drugs	283	341	58	575	708	133
Private Patient	870	878	8	1,860	1,890	30
VCC Over Activity	767	767	0	1,734	1,734	0
Radiation Protection	367	367	0	736	736	0
Staff Recharges	1,035	871	(165)	1,994	1,961	(33)
One Wales Palliative and EOL Care	4,277	4,277	0	5,450	5,450	0
Velindre Charity	1,248	1,203	(45)	2,567	2,465	(103)
Other Charity	529	523	(6)	972	990	18
RD&I*	1,707	1,708	1	3,907	3,769	(138)
HTW	465	465	0	1,100	1,100	0
Other Operating Income	2,932	2,872	(60)	4,192	4,085	(106)
Total	74,647	74,163	(485)	145,743	144,920	(823)

*RD&I full year budget includes £917k of Velindre Charity income.

The Trust has reported a cumulative year to date underachievement of **£(485)k** on Income, and is currently forecasting an outturn underachievement position of circa **£(823)k**.

- Welsh Transplantation and Immunogenetics Laboratory (WTAI) is currently £(253)k lower than planned and forecasting to be circa £(422)k which due to under activity in relation to Covid.
- Wholesale Blood components is not expected to achieve the £150k increased plasma income/ savings target this year due to the impact from Covid.
- Home Care Drugs overachievement is due to the increased homecare service of Oral drugs provided in relation to SACT since April.
- Staff recharges are underachieving by £(165)k due to vacancies which are not being recharged to other organisations to recoup the income, and will be offset by an underspend in staff.
- Velindre Charity income is also under target by £(45)k, outturn circa (£103)k due to vacancies within the service which are not being recharged to the Charity.
- RD&I forecasting a £(138)k due to reduced activity offset by underspends in both pay and non-pay.

4.2 Pay Analysis by Staff Group

STAFF GROUP	Cumulative £127k Underspend			Year End Forecast £141k Underspend		
	YTD	YTD	YTD	Full Year	Full Year	Forecast
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)
ADD PROF SCIENTIFIC AND TECHNICAL	1,122	1,105	17	2,321	2,295	27
ADDITIONAL CLINICAL SERVICES	3,332	3,111	221	6,428	5,986	443
ADMINISTRATIVE & CLERICAL	10,430	10,078	351	20,683	20,220	463
ALLIED HEALTH PROFESSIONALS	2,956	3,330	(374)	5,929	6,689	(760)
ESTATES AND ANCILLIARY	1,140	1,132	8	2,084	2,017	68
HEALTHCARE SCIENTISTS	4,005	3,832	173	7,987	7,779	208
MEDICAL AND DENTAL	5,659	5,603	56	11,329	11,461	(132)
NURSING	4,776	4,343	433	9,592	8,762	830
STUDENTS	37	37	0	37	37	0
SAVINGS & VACANCY FACTOR TARGET*	(740)	17	(758)	(1,339)	(335)	(1,004)
Total	32,715	32,588	127	65,051	64,910	141

The Trust has reported a cumulative year to date position underspend of **£127k** on Pay and is forecasting a year end outturn underspend position of circa **£141k**.

Agency Spend

Included within the various staff group expenditure values showing within the above table, the total **Agency spend** for September was £193k (August £212k), giving a cumulative year to date spend of **£1,305k** and a forecasted spend of circa **£1,806k**. Of these totals the year to date spend on agency directly related to Covid-19 is £236k and forecasted spend is circa £400k.

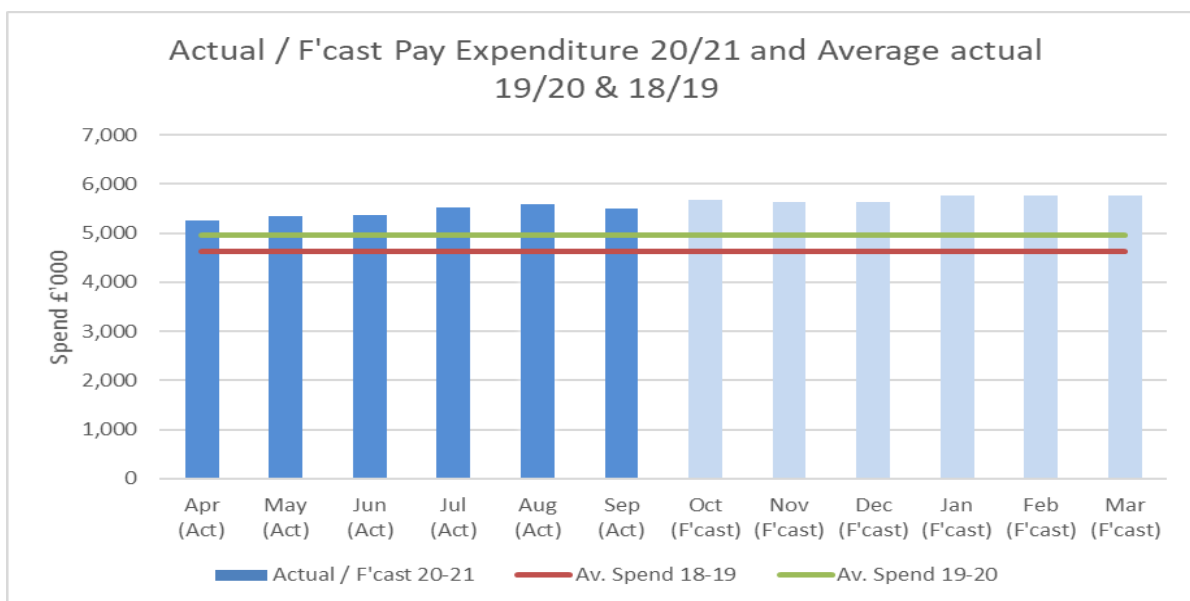
- Current vacancies against underspending staff groups are Admin & Clerical (7.9 wte), Healthcare Scientists (11.0 wte), Nursing (27.46 wte).

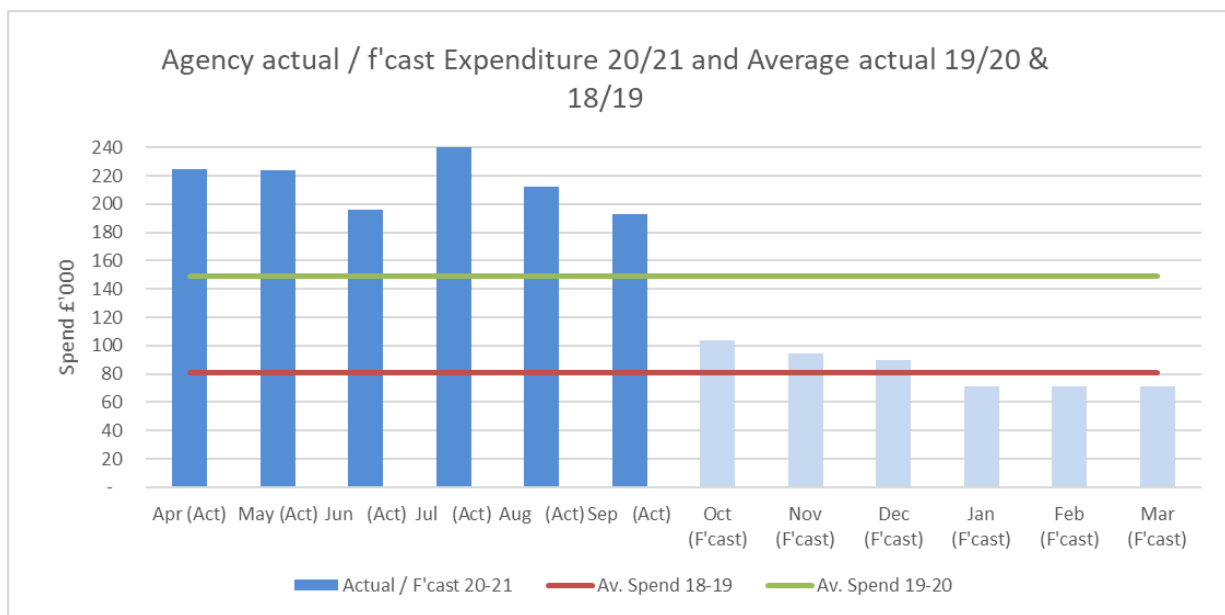
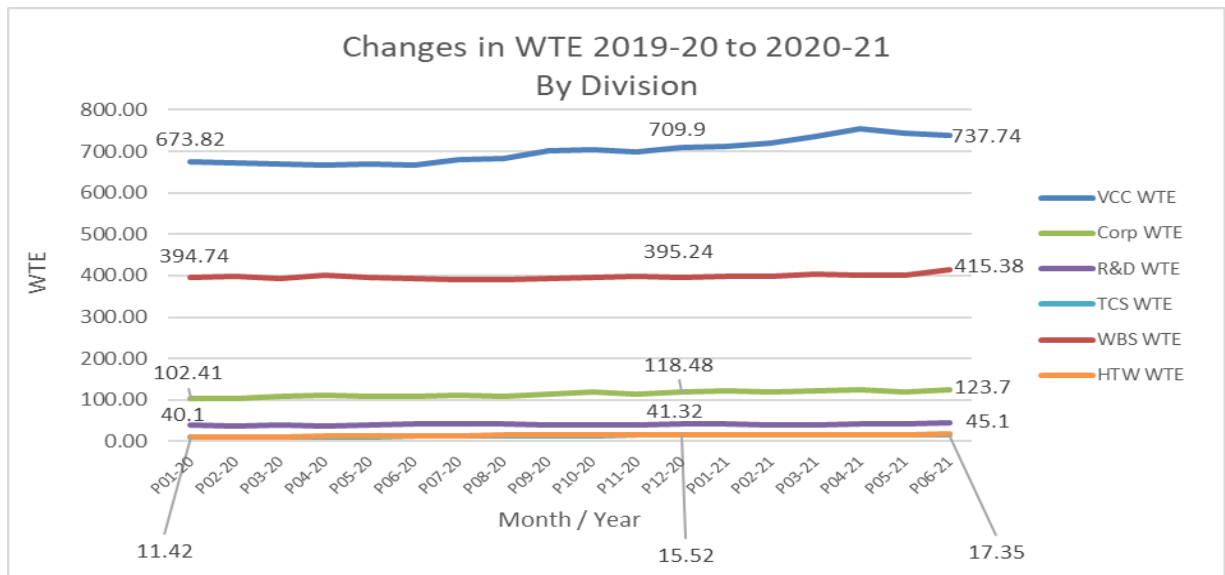
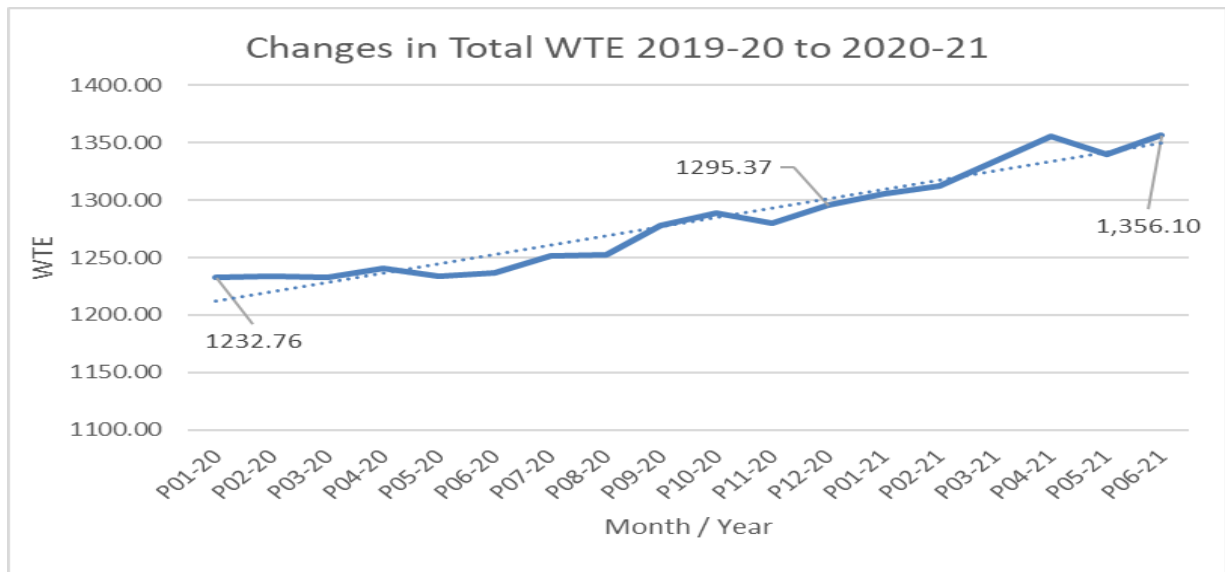
- Allied Health Professionals are experiencing an over spend of £(374)k which is due to the use of agency in Radiotherapy and Medical Physics to cover staff vacancies that the Trust has been unable to recruit to permanently, and staff off sick, or self-isolating due to Covid.
- Through the impact of Covid and the inability of the Trust to enact service redesign and generate staffing efficiencies the Trust is not expecting to achieve £350k of staff savings this year (£178k year to September), which is currently expected to be by funded by WG. The remaining underachievement against the savings and vacancy factor targets within the divisions is being achieved through underspends across numerous staffing groups, as illustrated in the above table.

Pay Spend Trends (Run Rate)

The pay spend for 19-20 was 12% above av. pay 18-19. 3% can be attributed to the pay award. 1.3% (£822k in total) relates to an increase in use of agency staff, and 6.3% the Increase in pension award which was accounted for in month 12. The remaining difference is a result of the additional staff recruited since the end of March'19 (c. 63 wte).

The pay spend for 20-21 (excluding the 6.3% increase in pension) is circa 9.4% above av. pay in 2019-20. 3% can be accounted for by the pay award, 2.4% can be accounted for by an increase in use of agency, with the remaining being the additional staff recruited over the latter part of 19/20, and since the beginning of 2020/21 (c. 61 wte), and pay costs associated with Covid-19.





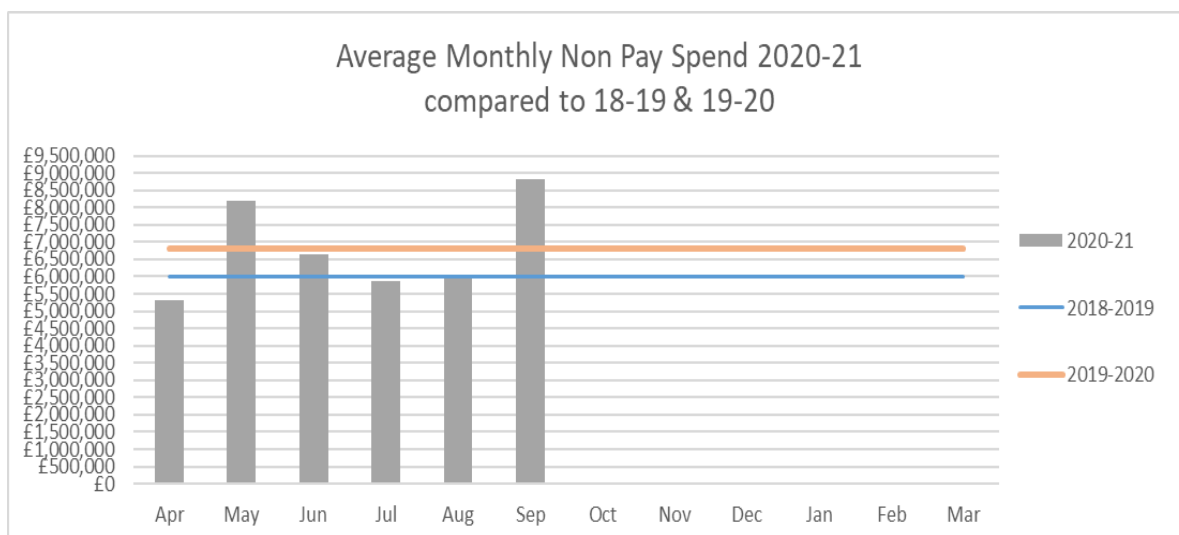
4.3 Non Pay Analysis

Income Type	Cumulative			Year End Forecast		
	£368k Underspend			£683k Underspend		
	YTD	YTD	YTD	Full Year	Full Year	Forecast
	Budget	Actual	Variance	Budget	Forecast	Variance
	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)
Nice & High Cost Drugs	15,013	15,013	0	34,368	34,368	0
Blood Wholesaling	5,464	5,439	25	12,435	12,409	25
Depreciation	3,209	3,209	0	6,418	6,418	0
Clinical Services & Supplies	2,787	2,688	99	5,681	5,349	332
Facilities Management	393	431	(38)	757	809	(52)
Maintenance & Repairs	1,435	1,356	79	2,860	2,801	60
General Drugs	5,742	5,571	171	2,625	2,299	326
Utilities/ Rent /Rates	1,161	1,136	24	2,295	2,277	19
General Services & Supplies	956	921	36	1,984	1,934	50
Blood Components	796	747	49	1,668	1,609	59
Transport	512	479	33	1,047	1,012	35
Printing / Stationary / Postage	373	313	60	832	817	15
Computer Maintenance & Supplies	373	479	(107)	717	867	(150)
Travel & Subsistence	247	152	95	561	409	153
Equipment & Consumables	164	195	(31)	280	326	(46)
Education & Development	127	106	20	301	237	64
NHS SLA	(532)	(531)	(1)	(858)	(856)	(2)
Audit Fees	144	143	1	306	307	(1)
Telecoms	145	160	(15)	234	263	(28)
One Wales End of Life Care	3,564	3,564	0	4,197	4,197	0
General Reserves / Savings Target	(143)	(9)	(134)	1,985	2,159	(174)
Total	41,932	41,565	368	80,693	80,010	683

The Trust has reported a cumulative year to date position of **£368k** underspent on Non-Pay and is forecasting an outturn forecast position of **£683k** underspent.

- Clinical Services is underspending due to a reduction in activity within both VCC and WBS as a result of Covid.
- General drugs is underspending due to low activity.
- Computer Maintenance & Supplies is over spending due to increased costs for maintenance costs including office 365.
- Transport, Travel & subsistence and Education are all underspending due to reduced activity in relation to Covid.
- General Reserves / Savings Target is currently reporting an overspend of £(134)k due to the Cost improvement Plans (CIP) held centrally within divisions. These CIP's are being achieved throughout other areas of non-pay as illustrated in the table.

Non-pay (c£81.6m) av. monthly spend increased by c£800k (10%) from £6m in 18-19 to £6.8m in 19-20. The monthly av. for 20-21 to M6 has increased from last month to match 19-20 average monthly spend of £6.8m.



*Non Pay includes £3.1m (£2.1m M2 and £1m M6) of Covid pass through expenditure funded via WG.

* VCC drug spend increased by circa £1.4m in September which is additional spend in month along with a catch up on processing of private patient drugs.

4.4 Covid-19

COVID-19 Revenue Spend		
Expenditure Type	YTD	Full Year
	Actual (£'000)	Forecast (£'000)
Pay	1,026	2,562
Non Pay	547	1,671
Non Delivery of Savings	176	350
External Income Loss	397	1,000
Reduction of Non Pay Costs Due to Reduced Elective Capacity	(250)	(490)
TOTAL	1,896	5,093
Total Funding Made Available		1,410
Balance of Funding Due		3,683
Hospice Funding Pass Through (fully received)		3,104

The Trust has currently received or had confirmation of funding from WG to the sum of £4,514k which leaves a current funding gap of £3,683k, against the total forecasted spend of £8,197k

The total year to date net additional expenditure on services directly related to Covid-19 is £4,999k. This incorporates actual gross expenditure of £4,974k, plus non delivery of savings of £275k, offset by a reduction in activity costs of £250k.

The full year net additional forecast cost amounts to £8,197k. Included within this forecast is expenditure of £3,104 relating to Hospice funding which is passing through the Trust and fully funded by WG. Additionally £1,153k relates to the all Wales Convalescent Plasma service which Welsh Government has asked the Trust to implement. The Trust has received a funding letter confirming that we will have access to funding up to a maximum of £1,153k for the Convalescent Plasma service during 2020-21. The Trust has also received £257k of funding from WG which covered the Covid-19 related staff costs for the period April- June. Consequently the current

unfunded forecast revenue expenditure directly associated with Covid 19 currently stands at £3,683k.

The total forecast cost includes a large proportion of estimated costs to provide additional capacity to meet an expected increase in demand later this year.

Additional Capacity

On the assumption that demand flows in accordance with the Trust projection, the Trust will be unable to deliver those activity levels within its current available resources, as the capacity would need to be increased significantly to meet the guidance for the safe return of healthcare environments to routine arrangements following the initial Covid-19 response. There will be a requirement for additional physical space and workforce resource to deliver activity levels in a safe way for both patients and staff. The Trust has considered options that could create sufficient additional physical capacity and resource it internally, or commission it externally to meet the uncertain demand.

The financial assessment included within this report and contained within the Month 6 submission to WG has a focus on creating capacity which could respond to demand increasing to pre-Covid levels within quarter 3 and at a level of 110/115% pre-Covid levels in quarter 4 to take account of suppressed demand within the system.

The amount required to provide this necessary additional capacity to cover Radiotherapy and SACT has been revised and now estimated at **£1m** (this is included in the above table) at this point (previously £3.1m). This incorporates a combination of increased and extended hours/days from internal resources and possible outsourcing options.

Previous demand projections indicated a return to pre-Covid activity levels from October onwards, and planned to tolerate a surge of up to 20% above historic levels. The revised demand projection represents a longer period in returning to pre-Covid levels of external referrals, indicative late December, and associated treatment capacity requirements in February/March. This is a significant shift in activity projections.

Work will continue on refining these estimates and the options that will be available.

5. Savings

The Trust established as part of the IMTP a savings requirement of £1,400k for 2020-21, (£1,200k) recurrent and (£200k) non-recurrent, with £1,000k being categorised as actual saving schemes and £400k being income generating schemes. Following a review of the schemes since the IMTP submission in January the savings are now categorised as £800k being actual saving schemes, and £600k being income generating schemes.

Within the identified savings, £650k of the schemes are now RAG rated as green, £700k have turned red in response to Covid-19, and a further £50k has turned red but with non-recurrent schemes being generated in its place. A significant proportion of the savings were expected to be delivered through service redesign and workforce rationalisation, which has been impossible to enact due to the capacity needs of delivering within the Covid-19 environment.

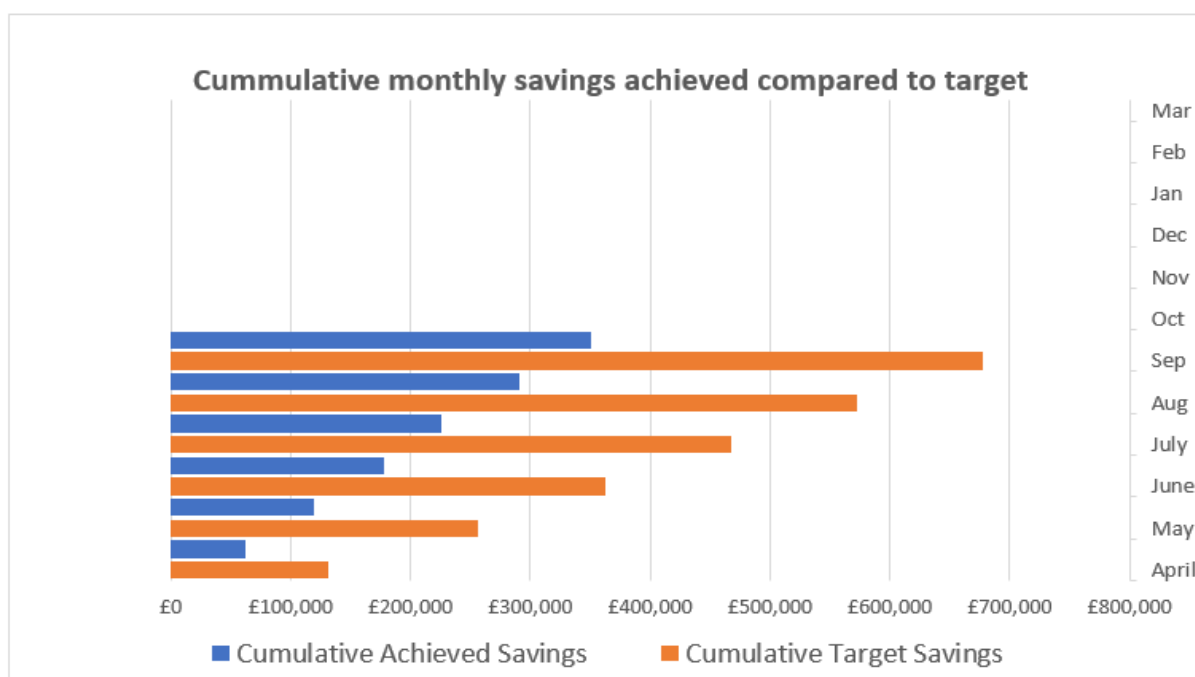
The Trust is currently forecasting a full year underachievement of **£(700)k** against the savings plans, £(279)k year to date, which is a direct result of Covid-19. The £700k is made up of four schemes within VCC (£550k) turning red, and one scheme within WBS (£150k). The Trust is

currently working to the assumption that any savings that are directly affected by Covid-19 will be fully funded by WG.

The Trust agreed as part of the IMTP submission that a balanced position will be carried into the next financial year. With the effect of Covid-19 having a huge impact (50%) against the savings target this year, it is extremely important that the Trust starts to develop plans for recurrent savings next year.

ORIGINAL PLAN		TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
VCC TOTAL SAVINGS		850	428	43	(386)	200	(650)
			10%			24%	
WBS TOTAL SAVINGS		450	152	143	(9)	337	(113)
			94%			75%	
CORPORATE TOTAL SAVINGS		100	50	50	0	100	0
			100%			100%	
TRUST TOTAL SAVINGS IDENTIFIED		1,400	630	236	(394)	637	(763)
TRUST ADDITIONAL NON-RECURRENT SAVINGS		0	0	115	115	63	63
ANTICIPATED WG COVID FUNDING FOR LOSS OF SAVINGS				0	0	700	700
TRUST TOTAL SAVINGS		1,400	630	351	(279)	1,400	0
			56%			100%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Service Redesign	Red	50	28	0	(28)	0	(50)
Premium of Agency Staffing	Red	150	75	0	(75)	0	(150)
Supportive Structures	Red	150	75	0	(75)	0	(150)
Procurement National and Local Value Plan	Red	50	25	0	(25)	0	(50)
Non Pay targeted Savings	Green	84	42	42	0	84	0
Non Recurrent Gains - Stock Management	Green	100	50	43	(7)	137	37
Review of Staffing	Green	116	60	58	(2)	116	0
Changes in Staffing Establishment	Green	100	50	50	0	100	0
Total Saving Schemes		800	405	193	(212)	437	(363)
Income Generation							
Productivity Gains	Red	200	100	0	(100)	0	(200)
Maximising Meds@Home opportunities	Green	50	25	28	2	50	0
Medicines Management (Secondary Care)	Green	100	50	0	(50)	50	(50)
Maximum income opportunities	Green	100	50	15	(35)	100	0
Increased Sale of Products	Red	150	0	0	0	0	(150)
Total Income Generation		600	225	43	(182)	200	(400)
TRUST ADDITIONAL NON-RECURRENT SAVINGS							
		0	0	115	115	63	63
ANTICIPATED WG COVID FUNDING FOR LOSS OF SAVINGS							
				0	0	700	700
Trust Total Savings		1,400	630	351	(279)	1,400	0
			56%			100%	



6. Reserves

The financial strategy for 2020-21 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. This could only be accommodated on the basis that all income expectations are received, planned savings schemes are delivered and new emerging cost pressures are managed. In addition the Trust holds an emergency reserve of 522k.

The current remaining available funding is shown below:-

	Recurring £k	Non Recurring £k
Unallocated Budget	88	77

Emergency Reserve		522
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7. End of Year Forecast / Risk Assessment

As highlighted in the Executive summary, the Trust is currently reporting a year end breakeven position against its revenue budget, however there are a number of risks which are being managed and closely monitored.

The table below summarises the key financial risks & opportunities which have also been highlighted to Welsh Government.

Risks

Overview Of Key Risks & Opportunities	FORECAST YEAR END	
	£'000	Likelihood
Risks (negative values)		
Covid 19: Expenditure incurred funding not received from WG	(2,983)	Medium
Covid 19: Savings Slippage	(700)	Medium
Non Deliver of Savings Plans (Amber Schemes)	(50)	Medium
Private Patient Income	(150)	Medium
Further Opportunities (positive values)		
Additional in Year Vacancy Factor	150	Medium

Covid-19 (Medium)

As detailed earlier the total forecasted expenditure on Covid-19 is £8,197k. This includes £2,562k of pay costs, £5,425k of non-pay costs, £(490)k of cost reduction, and £700k of slippage expected on delivery of savings.

Of the £8,197k forecast Covid-19 revenue expenditure, £3,104k relates to funding from WG passed on to the Hospices, £257k of funding received to support the staff costs for the first quarter of the year, and £1,153k relates to the WG funded All Wales Convalescent Plasma Service. This reduces the Trust risk related to Covid-19 down to £3,683k.

The Trust is currently assuming full recovery of costs from WG in relation to Covid-19.

Private Patient Income (Medium)

The Trust has lost c£150k income to the Rutherford Cancer Centre and from a number of insurance companies reducing the funding they are prepared to pay the Trust for the provisions of drugs, on which the Trust was including a mark-up on cost. This is in addition to any loss of income associated with Covid-19.

Other Risks not included in table

NHS Pension final pay controls

From April 2014, if a member of the pension scheme receives an increase to pensionable pay that exceeds the allowable amount then the Trust will be liable for a final pay control charge. It is extremely difficult to calculate the potential cost of the NHS pension final pay as the information required is not readily available. We are however continually monitoring any person that could potentially fall into this category, and where possible minimising any further potential risk.

Update on Contracting Arrangement with Commissioners

Due to the uncertainties associated with Covid 19 it has been agreed with our Commissioners that we will maintain a 'block contract' arrangement for the whole of the 2020/21 financial year. For Velindre this means that contracting income will be based on the 2019-20 outturn plus the agreed baseline uplifts until September.

Opportunities

Additional vacancies that could arise during the year could bring a potential opportunity above what is currently planned and will be used to help offset potential risks £150k.

8. CAPITAL EXPENDITURE

Administrative Target

- To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.
- To ensure the Trust does not exceed its External Financing Limit

	Approved CEL £000s	YTD Spend £000s	Committed Orders Outstanding £000s	Budget Remaining @ M5 £000s	Forecast Year End Spend £000s	Year End Variance £000s
All Wales Capital Programme						
Transforming Cancer Services	0	1,090	0	(1,090)	3,291	(3,291)
TCS - Radiotherapy Procurement Solution	548	211	0	337	548	0
IT - WPAS (CANISC replacement phase 2)	0	202	0	(202)	742	(742)
VCC CT Sim Replacement x2	1,557	778	165	614	1,557	0
WBS DNA Extracting Kit	50	0	53	(3)	50	0
WBS Foetal D	54	0	34	20	54	0
VCC - Treatment Planning System	44	1	0	43	44	0
Total All Wales Capital Programme	2,253	2,281	252	(281)	6,286	(4,033)
Covid-19						
COVID-19 WBS Plasmapheresis	397	226	0	171	397	0
COVID-19 Digital Devices	92	0	0	92	92	0
COVID-19 Other	946	946	0	0	979	(33)
Total Covid-19	1,435	1,172	0	263	1,468	(33)
Discretionary Capital	1,850	60	72	1,718	1,850	0
Sub Total	5,538	3,513	324	1,701	9,604	(4,066)
Charitable Funded Capital Scheme	45	0	0	45	45	0
TOTAL	5,583	3,513	324	1,746	9,649	(4,066)

The approved Capital Expenditure Limit (CEL) as at September 2020 was £5,538k for 2020-21 (excl Charity). This includes All Wales Capital funding of £2,253k, Covid-19 funding to date of £1,435k, and discretionary funding of £1,850k.

TCS

The TCS Programme is primarily funded from a capital budget allocation provided by WG. The medium to longer term capital requirements are outlined in the formal business cases that have been submitted to WG. The Trust has not received any budget allocation for the TCS programme for this financial year.

In the meantime we are having to rely on our discretionary capital budget to fund the on-going commitments which amount to a forecasted circa £150k to £200k per month. As at the end of September we have now exhausted all of our available discretionary capital budget to meet the unfunded expenditure under the TCS Programme. Therefore we are now unable to deliver other urgent discretionary capital needs across the Trust. The total forecast unfunded Capital requirement for the TCS Programme is currently expected to be circa £3.2m.

Covid-19

COVID-19 Capital Spend		
Expenditure Type	YTD	Full Year
	Actual (£'000)	Forecast (£'000)
Convalescent Plasma Service	226	397
Digital / IT Services	311	539
Equipment and Estates Works	635	1,067
TOTAL	1,172	2,003
Total Funding Made Available		1,435
Balance of Funding Due		568

The total committed Capital expenditure on Covid-19 is £1,468k, (spend to September £1,172k), which includes £397k for the convalescent plasma, and £92k for digital devices.

The Convalescent plasma funding of £397k and the Digital Devices £92k, along with £946k of the Covid funding requirement has been added to the Trust CEL. The Trust is waiting on confirmation from Welsh Government when the additional £33k of required funding included in the July return of undelivered Capital items will be released.

The service has identified a further capital demand in relation to Covid, which is largely based around making arrangements for social distancing, response to additional capacity, and IT kit. An additional request for Covid funding of £535k has been sent to WG in a recent update provided on the 15 September.

WPAS

The WPAS project has been delayed slightly due to relocation of staff in response to Covid. Therefore the expected funding requirement for 2020/21 has reduced by £150k from £892k to £742k. The £150k will still be required and a request will be made to WG for the funding to be added to the £892k baseline funding for 2021/22.

The Trust is still in negotiations with NWIS and WG in regards to transferring the funding into Velindre's CEL for 2020/21 which has been on hold due to Covid and the issues highlighted above around slippage.

CT SIM

During September the Trust returned the £400k projected underspend on CT Sim to WG. The remaining budget of c£600k is being held to decommission the third CT Sim, along with accommodation / refurbishment costs, and required equipment, however due to an expected increase in activity as a result of Covid-19 the service are potentially looking to delay the decommission by three months for contingency planning which could take some of the work into next financial year.

The work on CT sim will be closely monitored over the coming months.

Major Schemes in Development

In addition to the request for additional capital to cover future Covid related costs, as identified above, on the 15th September the Trust also provided WG with an update on other project funding

which the Trust is seeking in the current year from the All Wales capital Programme. This amounted to **£2.6m** for 2020/21 and covered the projects illustrated in the table below:

Scheme Title	2020/21 Requirement £k	2021/22 Requirement £k
VCC Fire Safety	600	650
VCC Ventilation	500	2,000
VCC Infrastructure	200	550
WBS HQ	300	2,400
Blood Gas Analyser	480	0
Flow Cytometer Replacement	550	0
Total All Wales Requirement	2,630	5,600

The Trust is current waiting on a response from WG on the 15th September submission.

Performance to date

The actual cumulative expenditure to September 2020 on the All Wales Capital Programme schemes was £2,281k, this is broken down between spend on the TCS Programme £1,090k, TCS Radiotherapy Procurement Solution £211k, WPAS £202k, TPS £1k, and CT SIM Replacement £778k.

The year to date spend related to Covid-19 is £1,172k.

There has been little movement on the Discretionary capital funding programme with the current uncertainty around funding for the TCS programme. The Capital planning group has however allocated £100k to both VCC and WBS, and £100k to Estates, along with £81k to Digital in order to allow for urgent small schemes to progress. The Trust is also developing schemes that will be ready to proceed once the Trust receives confirmation of funding from WG on the TCS programme, however there may be an impact on what schemes can be delivered this financial year if a decision on TCS is further delayed.

Year-end Forecast Spend

The year-end forecasted outturn is currently expected to be managed to a breakeven position.

Risks associated with the Capital Programme

Significant capital requirements identified across the Trust

- Unlikely to be 100% successful with bids to the All Wales Programme
- Currently using Discretionary funds to support the TCS programme
- Unfunded balance of £568k relating to Covid-19 spend
- Uncertainty over funding creates delays in decision making for use of Discretionary funds and impacts on deliverability.
-

9. BALANCE SHEET (Including Hosted Organisations)

The Balance Sheet in NHS Financial Statements is known as the Statement of Financial Position. It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

The statement shows the Trust's assets and liabilities. As part of the Trust SFIs there is a mandatory requirement to report movement in working capital.

Balance Sheet key movements between opening balance as at 1st Apr '20 and 30th September '20 and forecast closing balance as at 31st March '21.

Non -Current Assets

The **Increase of £1,070k** from 1st April to 30th September will relate to the agreed purchase from the Trust Capital programme, offset against the depreciation charges on Property, Plant & Equipment and Intangible assets.

Current Assets

Inventories (stock)

The **increase in stock of £56,676k** from 1st April to 30th September relates mainly to purchases of stock within NWSSP of £56,000k relating to Covid-19 which will be passed out to the HB's. The Trust is also still holding £7,000k of contingency stock from 2018-19 which WG asked both NWSSP and WBS to purchase in preparation for Brexit.

The Trust is intending to unwind the contingency stock during 2020-21 to repay the £7,000k cash provided by WG to purchase the Brexit, however given the precarious situation which has arisen due to Covid-19 the Trust is currently continuing to hold this stock

Cash and cash equivalents

Due to the high levels of purchases relating to Covid-19 within NWSSP, the cash levels are fluctuating significantly on a daily/ weekly basis. Cash levels are being continually monitored using a cash flow forecast in order to maintain appropriate levels.

Trade and other receivables

Trade and other receivables will move up and down each month depending on timing of when invoices are raised, and when the cash is physically received from debtors.

Current Liabilities & Non-Current Liabilities

Current Liabilities

Current Liabilities will move up and down each month depending on timing of when commitments are made, and invoices are received and paid.

	Opening Balance Beginning of Sep 20	Closing Balance End of Sep-20	Movement from 1st April to Sep-20	Forecast Closing Balance End of Mar 21
Non-Current Assets	£'000	£'000	£'000	£'000
Property, plant and equipment	129,554	130,624	1,070	129,554
Intangible assets	17,644	16,570	(1,074)	17,644
Trade and other receivables	862,962	861,947	(1,015)	862,962
Other financial assets				
Non-Current Assets sub total	1,010,160	1,009,141	(1,019)	1,010,160
Current Assets				
Inventories	13,134	69,810	56,676	21,134
Trade and other receivables	414,260	506,007	91,747	406,358
Other financial assets				
Cash and cash equivalents	18,263	52,527	34,264	18,263
Non-current assets classified as held for sale				
Current Assets sub total	445,657	628,344	182,687	445,755
TOTAL ASSETS	1,455,817	1,637,485	181,668	1,455,915
Current Liabilities				
Trade and other payables	(166,270)	(347,831)	(181,561)	(166,270)
Borrowings	(21)	0	21	0
Other financial liabilities				
Provisions	(272,376)	(272,503)	(127)	(272,503)
Current Liabilities sub total	(438,667)	(620,334)	(181,667)	(438,773)
NET ASSETS LESS CURRENT LIABILITIES	1,017,150	1,017,151	1	1,017,142
Non-Current Liabilities				
Trade and other payables				
Borrowings	(8)	0	8	0
Other financial liabilities				
Provisions	(863,259)	(863,259)	0	(863,259)
Non-Current Liabilities sub total	(863,267)	(863,259)	8	(863,259)
TOTAL ASSETS EMPLOYED	153,883	153,892	9	153,883
FINANCED BY:				
Taxpayers' Equity				
PDC	113,118	113,119	1	113,118
Retained earnings	12,432	12,440	8	12,432
Revaluation reserve	28,333	28,333	0	28,333
Other reserve				
Total Taxpayers' Equity	153,883	153,892	9	153,883

10. CASH FLOW (Includes Hosted Organisations)

Cash held in the Trusts bank account is a key indicator of its financial health in terms of income, expenditure and surplus or deficit. The Trust is mainly reliant on its commissioners for cash, however if the Trust has a deficit it would need to secure a loan from Welsh Government to cover the cash shortfall created by the deficit.

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties and can liaise with Welsh Government to secure a loan.

As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products have been purchased by WBS, to provide resilience for NHS Wales due to the precarious decision around Brexit.

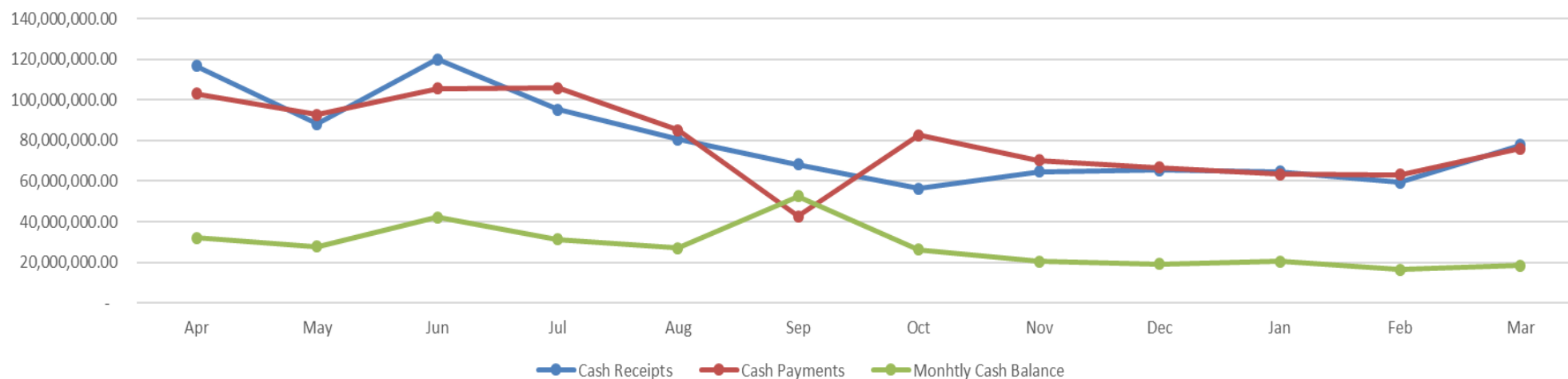
To aid the Trust's cash flow while the stock was being held for Brexit, Welsh Government have provided the Trust with additional cash of £7m during 2019/20 with the intention that it is repaid during 2020/21. WBS did intend on starting to run down the stock from April, however given the precarious situation with Covid-19 the Trust will continue to hold this stock until further notice. NWSSP are currently reviewing the timing of the All Wales Brexit stock run down.

Due to the high levels of purchases relating to Covid-19 within NWSSP the cash levels are expected to be significantly higher than usual for the first five months of the year and maybe beyond. The cash balance is also considerably fluctuating on a daily/ weekly basis.

Cash levels are being continually monitored using a cash flow forecast in order to maintain appropriate levels.

		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Totals £'000
	RECEIPTS													
1	LHB / WHSSC income	20,362	26,383	20,839	55,869	25,973	21,360	21,500	24,800	25,500	27,900	26,860	29,930	327,276
2	WG Income	93,193	44,297	70,821	25,015	47,924	44,323	32,800	38,098	37,800	34,680	30,200	38,140	537,291
3	Short Term Loans													0
4	PDC	135											7,204	7,339
5	Interest Receivable	3	4	0	4	4	0	0	0	0	0	0	0	15
6	Sale of Assets													0
7	Other	3,176	17,499	28,494	14,317	6,817	2,648	1,920	1,752	2,058	2,100	2,200	2,560	85,542
8	TOTAL RECEIPTS	116,869	88,184	120,154	95,205	80,718	68,331	56,220	64,650	65,358	64,680	59,260	77,834	957,463
	PAYMENTS													
9	Salaries and Wages	15,946	15,958	16,323	16,424	18,048	19,137	20,067	20,099	20,376	21,430	21,933	22,310	228,051
10	Non pay items	84,539	75,671	88,129	87,538	65,800	22,200	60,600	48,240	37,600	40,300	38,450	49,224	698,292
11	Short Term Loan Repayment													0
12	PDC Repayment													0
14	Capital Payment	2,551	1,004	1,167	2,030	1,380	1,351	1,980	1,902	1,800	1,655	2,800	4,500	24,120
15	Other items									7,000				7,000
16	TOTAL PAYMENTS	103,036	92,633	105,619	105,992	85,228	42,688	82,647	70,241	66,776	63,385	63,183	76,034	957,463
17	Net cash inflow/outflow	13,832	(4,450)	14,535	(10,787)	(4,510)	25,643	(26,427)	(5,591)	(1,418)	1,295	(3,923)	1,800	
18	Balance b/f	18,263	32,095	27,646	42,181	31,394	26,884	52,527	26,100	20,509	19,091	20,386	16,463	
19	Balance c/f	32,095	27,646	42,181	31,394	26,884	52,527	26,100	20,509	19,091	20,386	16,463	18,263	

Monthly Cash Flow Forecast



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Full Year Forecast	Year End Variance
	£000	£000	£000	£000	£000	£000
VCC	16,862	17,136	(274)	34,428	34,428	0
RD&I	(29)	(128)	99	(474)	(474)	0
WBS	9,945	9,763	182	21,176	21,176	0
Sub-Total Divisions	26,778	26,771	7	55,130	55,130	0
Corporate Services Directorates	2,932	2,928	4	6,031	6,031	0
Delegated Budget Position	29,710	29,700	11	61,161	61,161	0
TCS	268	268	0	536	536	0
Health Technology Wales	8	9	(1)	0	0	0
Non recurrent measures to achieve financial breakeven general reserves	0	0	0	0	0	0
Trust Position	29,986	29,976	10	61,697	61,697	0

VCC

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£000	£000	£000	£000	£000	£000
Income	27,112	26,899	(213)	48,666	48,712	46
Expenditure						
Staff	18,781	19,032	(251)	37,049	37,529	(481)
Non Staff	25,193	25,003	191	46,045	45,610	435
Sub Total	43,974	44,035	(61)	83,093	83,139	(46)
Total	16,862	17,136	(274)	34,428	34,427	0

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre at the end of September 2020 was an overspend of **£(274)k** representing 0.3% of the division's annual budget. VCC is currently expecting to achieve an outturn position of **breakeven**.

Income at Month 6 was **£(213)k** under achieved, this primarily relates to non-achievement of the Income savings target and reduced levels of private patients income. Canteen takings are also down due to reduced activity in the hospital. Partly offset with overachievement of Physics Management HSST income, homecare VAT savings from increased chemo, and additional income from Top up Drugs along with other small variances

Staff was **£(251)K** overspent as at Month 6. The major factor contributing to the overspend is the cost of agency which totals £(766)k as at the end of September, with additional activity in Radiotherapy and Medical Physics being the main cause. There are underspends across the division due to vacancies which is above vacancy factor and the service redesign savings target, which is helping to offset some of the agency costs.

Non Staff Expenditure at Month 6 was **£191k** underspent. The main reason for the underspend is on the general drugs budget, and various underspends across other services due to low activity, such as Nursing, Radiology, and patient appliances (wigs). Partly offset with an overspend in Pharmacy due to one off maintenance costs for Chemo Care, Medical Oncotype spending, and the non-achievement of savings plans.

WBS

	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Full Year Forecast	Year End Projected Variance
	£000	£000	£000	£000	£000	£000
Income	7,638	7,358	(279)	16,658	16,034	(624)
Expenditure						
Staff	8,291	8,020	271	16,591	16,200	391
Non Staff	9,292	9,102	190	21,244	21,011	233
Sub Total	17,583	17,122	461	37,835	37,210	624
Total	9,945	9,763	182	21,176	21,176	0

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of September 2020 was an under spend of **£182k** representing 0.8% of the division's annual budget. WBS is currently expecting to achieve an outturn position of **breakeven**.

Income underachievement to date is **£(279)k**, where activity is lower than planned on Plasma Sales, Bone marrow and Neqas due to Covid-19 suppressed activity.

Staffing underspend continues to be high with a **£271k** under spend reported to September, which is above the divisions vacancy factor target. Vacancies remain high though decreasing based on recent recruitment with additional staff commencing from September. Convalescent plasma staff commenced from August as part of phase 1, with Phase 2 and 3 having started in September which is fully funded by WG.

Non Staff underspend of **£190k** is largely due to reduced costs from suppressed activity, Underspend on collections services, Laboratory Services, and WTAIL, (business Systems & Centre service), and rephrasing of non-pay contingency into M12 to support increased activity and staff recruitment post Covid.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	4,330	4,337	7	5,412	5,304	(108)
Expenditure						
Staff	3,660	3,637	23	7,278	7,139	139
Non Staff	3,602	3,628	(26)	4,166	4,196	(31)
Sub Total	7,262	7,265	(3)	11,443	11,335	108
Total	2,932	2,928	4	6,031	6,031	0

Corporate Key Issues:

The reported financial position for the Corporate Services Division at the end of September 2020 was an under spend of **£4k** representing 0.035% of the division's annual budget. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

Income position is expected to underachieve by circa £(108)k due to a reduction in bank interest following the rate changes earlier in the year. Staff recharge income will also under achieve due to the Charity Director post becoming vacant and no longer recharged to the Charity which will be offset by an underspend in staff.

Staff underspends are due to vacancies which are partly being offset by the use of agency staff.

Non pay overspend is due to unachieved savings target, partly offset by asset and debt recovery savings, and the sale of an asset.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	1,708	1,708	1	3,907	3,769	(138)
Expenditure						
Staff	1,335	1,251	84	2,789	2,697	92
Non Staff	343	330	14	644	598	46
Sub Total	1,678	1,581	98	3,433	3,295	138
Total	(29)	(128)	99	(474)	(474)	0

RD&I Key Issues

The reported financial position for the RD&I Division at the end of September 2020 was an under spend of **£99k** representing 2.88% of the total divisional budget. RD&I is currently expecting to achieve an outturn position of **breakeven**.

Staff cost underspends of £87k are due to Vacancies and maternity leave in the Trials delivery team.

Non-Staff related underspends £14k are due to Savings from a reduction in Trials activity.

TCS – (Revenue)

	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Full Year Forecast	Year End Projected Variance
	£000	£000	£000	£000	£000	£000
Income	0	0	0	0	0	0
Expenditure						
Staff	268	270	(3)	536	536	0
Non Staff	0	(3)	3	0	0	0
Sub Total	268	268	0	536	536	0
Total	268	268	0	536	536	0

TCS Key Issues

The reported financial position for the TCS Programme at the end of September 2020 was breakeven with a forecasted outturn position of **breakeven**.

HTW

	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Full Year Forecast	Year End Projected Variance
	£000	£000	£000	£000	£000	£000
Income	465	465	0	1,100	1,108	8
Expenditure						
Staff	380	378	2	809	796	13
Non Staff	93	96	(3)	291	312	(21)
Sub Total	473	474	(1)	1,100	1,108	(8)
Total	8	9	(1)	0	0	0

HTW Key Issues

The reported financial position for Health Technology Wales at the end of September 2020 was **£(1)k overspent**, with a forecasted outturn position of **breakeven**.

A small underspend of £2k in staff was offset by a £3k overspend in non-staff.

HTW is fully funded by WG.

Appendix 1

TCS PROGRAMME DELIVERY BOARD

TCS PROGRAMME FINANCIAL REPORT FOR 2020-21 SEPTEMBER 2020

DATE OF MEETING	12 th October 2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Mark Ash, Assistant Director of Finance - TCS Programme
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PRESENTED BY	Mark Osland, Executive Director of Finance
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EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance
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REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
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COMMITTEE OR GROUP	DATE	OUTCOME
N/A		Choose an item.

ACRONYMS	
TCS	Transforming Cancer Services
Trust	Velindre University NHS Trust
nVCC	New Velindre Cancer Centre
WG	Welsh Government
PMO	Programme Management Office

1. PURPOSE

- 1.1 The purpose of this report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2020-21, outlining spend to date against budget as at Month 06 and current forecast.

2. BACKGROUND

- 2.1 In January 2015 the Minister for Health and Social Services approved the initial version of the Strategic Outline Programme 'Transforming Cancer Services in South East Wales'. Following the completion of the Key Stage Review in June/July 2015, approval was received from the Minister to proceed to the next stage of the Programme.
- 2.2 It should be noted that as at March 2020, the Cabinet Secretary for Health, Well-being and Sport, has approved capital and revenue funding for the TCS Programme and its associated Projects. The total cumulative expenditure as at the end of March 2020 was £17.375 Capital and £2.621m for Revenue.
- 2.3 In addition to WG funding, NHS Commissioners agreed in December 2018 to provide annual revenue funding towards the TCS Programme, £0.400m of which was provided in 2018/19, £0.420m in 2019-20, and £0.420m in 2020-21.
- 2.4 In the financial year 2019-20, the Trust provided the nVCC and Enabling Works projects with £0.060m of revenue funding from its own baseline revenue budget. Previously direct revenue support for these projects had been provided by WG. .
- 2.5 The Radiotherapy Procurement Solution PBC (Project 3 – Equipment and Digital) was endorsed by WG in 2019-20. Capital funding of £1.110m was approved from July 2019 to December 2022, with £0.347m provided in 2019-20. Re-profiling of the funding resulted in a revised funding allocation of £0.250m for the 2019-20 financial year. The slippage of £0.097m has been reprovided in the next financial year, increasing the allocation for the financial year 2020-21 from £0.451m to £0.548m.

3. FUNDING

Funding provision for the financial year 2020-21 is outlined below. The following should be noted:

- 3.1 There are ongoing discussions with Welsh Government regarding the capital funding for the nVCC and EW Project(s). The funding envelope would be in the region of £3.0m and £3.5m.

- 3.2 No revenue funding has been provided by Welsh Government to date to cover project delivery costs for 2020-21 for the Enabling Works and nVCC Projects.

Description	Funding	
	Capital	Revenue
Programme Management Office There is no capital funding requirement for the PMO at present Allocation from funding provided from Commissioners for 2020-21 to cover direct clinical/management support and PMO	£nil	£0.240m
Project 1 – Enabling Works for nVCC Project 2 – nVCC <i>WG Capital Funding</i> Capital funding from WG to be confirmed <i>Revenue Funding</i> No Revenue funding provided by WG for the financial year 2020-21 to date	£nil	£nil
Project 3a – Radiotherapy Procurement Solution £0.451m capital funding provided in 2020-21 plus £0.097m capital funding reprovided from 2019-20	£0.548m	£nil
Project 4 – Radiotherapy Satellite Centre Project is led and funded by the hosting organisation, Aneurin Bevan University Health Board, and no funding requirement is expected from the Trust for 2020-21	£nil	£ nil
Project 5 – SACT and Outreach Funding has been requested for this project however none has been provided to date	£nil	£nil

Description	Funding	
	Capital	Revenue
Project 6 – Service Delivery, Transformation and Transition No capital funding requirement at present Allocation from funding provided from Commissioners for 2020-21 to cover direct clinical/management support and PMO Funding provided from the Trust's core revenue budget towards the costs of the Project Director post Funding transferred from Velindre Cancer Centre toward the costs for the Project Manager post Funding provided from the Trust's core revenue budget for the Acute Oncology Service Business Justification Case	£nil	£0.180m £0.067m £0.049m £0.035m
Project 7 – VCC Decommissioning No funding requested or provided for this project to date	£nil	£nil
Total funding provided to date: £1.119m	£0.548m	£0.571m

4. FINANCIAL SUMMARY AS AT 30TH SEPTEMBER 2020

- 4.1 The summary financial position for the TCS Programme for the year 2020-21 is outlined below:

TCS Programme Budget & Spend 2020/21

CAPITAL	Current Month			Financial Year		
	Budget to Sep-20	Spend to Sep-20	Variance to Sep-20	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	0	71,073	-71,073	0	170,678	-170,678
Project 1 - Enabling Works	0	25,088	-25,088	0	83,044	-83,044
Project 2 - New Velindre Cancer Centre	0	332,456	-332,456	0	779,107	-779,107
Project 3a - Radiotherapy Procurement Solution	208,000	194,047	13,953	416,000	388,030	27,970
Other Project Staff	0	59,097	-59,097	0	118,195	-118,195
Capital Pay Total	208,000	681,760	-473,760	416,000	1,539,054	-1,123,054
NON-PAY						
nVCC Project Delivery	0	10,093	-10,093	0	76,633	-76,633
Project 1 - Enabling Works	0	407,471	-407,471	0	1,249,841	-1,249,841
Project 2 - New Velindre Cancer Centre	0	241,993	-241,993	0	813,265	-813,265
Project 3a - Radiotherapy Procurement Solution	17,500	17,155	345	132,000	159,970	-27,970
Capital Non-Pay Total	17,500	676,712	-659,212	132,000	2,299,709	-2,167,709
CAPITAL TOTAL	225,500	1,358,472	-1,132,972	548,000	3,838,763	-3,290,763

REVENUE	Current Month			Financial Year		
	Budget to Sep-20	Spend to Sep-20	Variance to Sep-20	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	120,000	99,347	20,653	240,000	198,222	41,778
Project 6 - Service Change Team	147,795	148,451	-655	295,591	296,759	-1,168
Revenue Pay total	267,795	247,798	19,997	535,591	494,981	40,610
NON-PAY						
nVCC Project Delivery	0	12,536	-12,536	0	30,123	-30,123
Programme Management Office	0	1,176	-1,176	0	41,778	-41,778
Project 6 - Service Change Team	0	5,134	-5,134	35,000	35,267	-267
Revenue Non-Pay Total	0	18,845	-18,845	35,000	107,169	-72,169
REVENUE TOTAL	267,795	266,644	1,152	570,591	602,150	-31,559

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 30TH SEPTEMBER 2020

CAPITAL SPEND

Projects 1 and 2 Pay Costs

- 5.1 **WG Funded Staffing** - An in-year spend of £0.428m for posts funded by WG reflects the current 'interim' posts, with a forecast spend of £1.033m for the year. The pay costs have been analysed by each element of the Project(s).
- 5.2 **Other Project Staff** - There is an in-year spend of £0.059m to date with a forecast spend of £0.118m for the year.

Projects 1 and 2 Non-Pay Costs

- 5.3 **nVCC Project Delivery** - There is a capital cost of **£10k** for the year to date for project support and running costs for Projects 1 and 2, made up of IT purchases, travel and subsistence, and general office costs. There is also a credit of £3k due to over accrual of travel and subsistence costs. These are expected to resume later in the year. The forecast spend for the financial year 2020-21 is **£0.077m**, with the budget is to be confirmed.
- 5.4 **Enabling Works** - There is an in-year capital spend of **£0.433m**, with a forecast spend for the year of **£1.333m**. The budget is to be confirmed.

Work package	Spend to 30 th September 2020
Pay	£0.025m
Planning (inc TCAR & Asda)	£0.061m
Master Planning & Feasibility Study	£nil
Third Party Undertakings	£0.077m
Enabling Works - Design & Employers Requirements	£0.256m
Enabling Works – Works	£0.001m
Miscellaneous Works – Fol Legal Advice	£0.012m

- 5.5 **nVCC** - There is an in-year capital spend of **£0.646m**, with a forecast spend for the year of **£1.763m**. The budget is to be confirmed.

Work package	Spend to 30 th September 2020
Pay (including Project Leadership)	£0.404m
Project Agreement (PA)	£0.059m
Procurement Documents (PD)	£0.083m
Land Transfer	£0.018m
nVCC Technical Support	£0.076m
Competitive Dialogue Preparedness	£nil
Competitive Dialogue - PQQ & Dialogue	£nil
Miscellaneous Works – Fol Legal Advice	£0.005m

Project 3a – Radiotherapy Procurement Solution

- 5.6 There is an in-year spend of **£0.211m** (£0.194m pay, £0.017m non-pay) for the Integrated Radiotherapy Solutions Procurement Project against a budget of **£0.223m**. The previous month's overspend of £36k due to legal work has been offset by the release of 2019-20 year end accruals. There remains an underspend in pay due to part of the costs for the Director of Commercial & Strategic Partnerships being met by the TCS PMO. The Project is currently forecasting a break even position against a budget for the year of **£0.548m**.

REVENUE SPEND

Programme Management Office

- 5.7 The PMO spend to date is **£0.101m** against a budget of **£0.120m**, made up of pay costs £0.099m and non-pay costs of £1.1k. The underspend of £19k is due to the reduced costs for the Associate Director of Programmes. The forecast outturn for the financial year 2020-21 is **£0.240m** against a budget of the same.

Projects 1 and 2 Delivery Costs

- 5.8 There is a revenue project delivery cost for the nVCC and Enabling Works Projects of **£13k** to date, with an expected spend for the year of **£30k**. This includes rates and other running costs. No revenue budget has been provided to date.

Project 6 – Service Delivery, Transformation and Transition (Service Change)

- 5.9 Service Change spend to date is **£0.154m** against a budget of **c£0.148m**. This is made up of pay costs of £0.148m and non-pay costs of £5k for Healthcare Planner support for the Acute Oncology Services Business Justification Case (AOS BJC). The Project is forecasting a spend of **£0.332m** against a budget of **£0.331m**.

6. CONSIDERATIONS FOR BOARD

- 6.1 An extract of this report is reported in the Trust Boards Finance Report.

7. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	See above.

8. RECOMMENDATION

- 8.1 The TCS Programme Board are asked to **ENDORSE** the financial position for the TCS Programme and Associated Projects for 2020-21 as at 30th September 2020.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE

DATE OF MEETING	26 th November 2020
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Martin Veale, Independent Member
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance
REPORT PURPOSE	FOR NOTING
ACRONYMS	
IA NWIS	Internal Audit NHS Wales Informatics Service

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Audit Committee at its meeting on the 8th October 2020.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	
ADVISE	<p>NWIS</p> <p>NWIS's transition to the Strategic Health Authority is now a standing agenda item at Audit Committee meetings. The Committee received verbal updates from the Director of Finance at NWIS and from a representative from Welsh Government.</p> <p>The project structure was described and the Committee heard from Trust Officers how work was being planned and was progressing. The Committee asked for highlight reports to be provided to them, and for the Executive Director of Finance and Director of Corporate Governance to consider whether additional Audit Committee meetings could be scheduled prior to the transfer to allow them to remain engaged and updated with progress and any issues on a timely basis.</p>
ASSURE	<p>Internal Audit Programme</p> <p>The Committee received the IA Progress Report and were informed that the following reports have been finalised during the period:</p> <ul style="list-style-type: none"> • Environmental Sustainability Report – Reasonable Assurance • Annual Quality Statement – Reasonable Assurance • Governance Arrangements during the COVID-19 Pandemic (Advisory Review) • Water Safety Management – Reasonable Assurance <p>The Committee also received and noted the Velindre Cancer Centre Development Integrated Assurance Plan for 2020/2021.</p> <p>The Committee received the NWIS Internal Audit Operational Plan for 2020/2021 and confirmed that one formal audit report would be presented to the next meeting.</p> <p>Audit Action Tracker</p> <p>The Committee received the report which showed actions completed since the last meeting, and those which had now become overdue. Some action owners had requested extensions to deadlines which the Committee agreed, and where no updates had been provided or extensions requested, the Committee identified revised dates they felt would be appropriate from the</p>

	<p>information available to them. It was noted that improvements to the data and updates provided had been made since the last report was received.</p> <p>The Committee also received a report showing all outstanding actions which is presented on an annual basis to enable full oversight of actions outstanding but not yet due.</p> <p>Clinical Audit Plan 2020/2021</p> <p>The Executive Medical Director joined the meeting to present the Clinical Audit Plan. The Committee noted the contents of the plan and asked for Highlight Reports to be shared with them.</p>
INFORM	<p>Counter Fraud</p> <p>The Committee received an update from the Local Counter Fraud Specialist on the Work plan for 2019/2020, in addition to the progress report at 31st August 2020.</p> <p>Audit Wales also presented a report to the Trust on the Effectiveness of its Counter Fraud Arrangements, with management responses included and noted by the Committee.</p> <p>Other Business</p> <p>The Committee also received written or verbal reports under the following agenda items:</p> <ul style="list-style-type: none"> • Proposed Committee Structure • Development of the Risk and Assurance Strategy & Framework • Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria Register • Finance Technical Update relating to the New International Financial Reporting Standard 16 – Accounting for Leases • Audit Wales & Internal Audit updates • Audit of Accounts Report Addendum (Management Letter) from Audit Wales • Structured Assessment 2020 Report from Audit Wales • 'Raising our Game' Tackling Fraud in Wales Report from Audit Wales • Procurement Compliance Report
APPENDICES	NOT APPLICABLE

TRUST BOARD

CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	26/11/2020
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance
REPORT PURPOSE	FOR NOTING
ACRONYMS	
CFC	Charitable Funds Committee

1. PURPOSE

- 1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Charitable Funds Committee at its meeting on the 4 November 2020.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	No items to escalate this period.
ADVISE	<p>View from a Fundraiser The Committee received a presentation from Wayne Griffiths, Charity Ambassador, to provide the Committee with an overview of the fundraising activity that had taken place for the 'Rhian Griffiths Forget Me Not Fund' since its launch in 2012 and noted that a total of around £570,245 has been raised</p> <p>The Committee welcomed the opportunity to learn about the experiences of the Charity ambassadors and it was agreed that patrons and ambassadors of the Charity are to be invited to attend future meetings to share their experiences to help ensure learning from the voice of the fundraiser at the Committee.</p> <p>Fundraising Activity The Committee commended the work of the Fundraising Team as highlighted within the Fundraising Update Report in what had been a tremendously difficult first six months of the year for the Charity. The Committee acknowledged how innovative our fundraisers have been during this period with diversification into other areas and that more people have decided to adopt Velindre e.g. Cardiff Airport. Thanks were expressed to the team.</p> <p>Overseas Fundraising Events All of the overseas events planned for the current year have been postponed and have been rescheduled for various dates in 2021/22. Fundraising activity for these events continues but has been severely impacted by the Pandemic. The deadlines for fundraising to support the overseas events will be extended in line with the revised event dates.</p> <p>Fundraising 2020-21 and 2021-22 The Committee were advised that fundraising income for the current financial year is on course to meet the revised reduced income target of £1.6m, largely down to the generous one-off donation of £500k from the Moondance Foundation.</p> <p>However the next financial year is going to be very challenging in the continued context of COVID-19, consistent with the position of all charities across the UK. There has been an upsurge this year with virtual fundraising and Velindre has successfully diversified, however, it is recognised that with the continued global challenge around fundraising activity, due to the restrictions in place it is anticipated that next year fundraising activity will be difficult.</p> <p>Business Case Evaluations The Committee received the following business case evaluations:</p>

	<ul style="list-style-type: none"> • *Medical Physics Expert • * R&D Nursing • * Small Grants Scheme • R&D Officer • *Oncology Physiotherapist • *Continuation of funding for GI CNS • Consultant Radiographer • WCB Supporting Lung Research through Biosample Collection • National Thyroid • Gynae Radiotherapy • Radiotherapy Fundraising <p>A number of the Business Cases Evaluations are to be re-submitted to the Committee with additional details provided by the service leads for further clarification and assurance. (* Denotes requested further clarification and information). Going forward there is a new template for business case evaluations and grant holders will be required to complete all sections.</p> <p>Business Case / Expenditure Proposals The Committee approved the following expenditure proposals:</p> <ul style="list-style-type: none"> • Thyroid Cancer Research Initiatives • Full Blood Points of Care (no cost extension)
ASSURE	<p>Charitable Funds Committee Annual Report 2019 The Annual Report was received by the Committee and approved for noting by the Trust Board on 26 November 2020. The Annual Report details the activities and performance for the Charitable Funds Committee for the reporting period January 2019– December 2019.</p> <p>Charitable Funds (Trustee) Annual Report 2019-20 The first draft of the Annual Report was received by the Committee for review, in readiness for circulation to all Trustees, ahead of final approval by the Committee in December and submission to the Charity Commission by the 31st January 2021.</p> <p>As with previous years, the aim of the annual report is to demonstrate how the money raised through Charitable Funds allows the Charity to make a difference and enhance the services provided.</p>
INFORM	<p>Appointment of New Ambassadors The Committee received three new Ambassador nominations which were approved by the Committee. The Chair will now write to the each of the nominees inviting them to join the Charity as an Ambassador.</p>
APPENDICES	Not applicable.

PUBLIC TRUST BOARD

ASSURANCE REPORT FROM THE CHAIR OF THE VELINDRE UNIVERSITY NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

Meeting Date:	26 November 2020
Author:	Roxann Davies, Corporate Services Manager, NHS Wales Shared Services Partnership
Sponsoring Executive Director:	Lauren Fear, Interim Director of Corporate Governance, Velindre University NHS Trust
Report Presented by:	Lauren Fear, Interim Director of Corporate Governance, Velindre University NHS Trust

Trust Resolution to: (please tick) <input checked="" type="checkbox"/>			
APPROVE:	<input type="checkbox"/>	REVIEW:	<input type="checkbox"/>
INFORM:	<input checked="" type="checkbox"/>	ASSURE:	<input checked="" type="checkbox"/>
Recommendation:	For the Board to review and NOTE .		

This report supports the following Trust objectives as set out in the Integrated Medium Term Plan: (please tick) <input checked="" type="checkbox"/>	
Equitable and timely services	<input checked="" type="checkbox"/>
Providing evidence based care and research which is clinically effective	<input type="checkbox"/>
Supporting our staff to excel	<input type="checkbox"/>
Safe and reliable services	<input checked="" type="checkbox"/>
First class patient/donor experience	<input type="checkbox"/>
Spending every pound well	<input checked="" type="checkbox"/>
Acronyms:	
NWSSP – NHS Wales Shared Services Partnership SSPC – Shared Services Partnership Committee SLT – Senior Leadership Team	NHAIS – National Health Application and Infrastructure Services PPE – Personal Protective Equipment
Executive Summary:	
This paper has been prepared to provide the Velindre Trust Board with details of the key issues considered by the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership, at its meeting on 20 October 2020. The Board is requested to NOTE the contents of the report and actions being taken. Key assurances and highlights from the meeting are reported overleaf:	

ALERT	No matters to alert/escalate.
ADVISE	No matters to advise.
ASSURE	<p>External Audit</p> <p>Audit Wales presented a detailed Position Statement which set out an update as to current and planned audit work, together with the Auditor General's planned programme of topical publications, related studies, good practice, and national events that may be of interest to the Committee, which would be held remotely in the current circumstances. All assurance work had been completed and findings from that work were summarised as follows:</p> <ul style="list-style-type: none"> • <u>Audit Wales Management Letter 2019-20</u> The letter summarised the services provided by NWSSP, of which no significant issues were raised that would prevent reliance on NWSSP's services. The report made 3 recommendations which were agreed with Management. • <u>Audit Wales Nationally Hosted NHS IT Systems Report 2019-20</u> The scope of the audit looked at four IT systems; prescription pricing system, NHAIS, Oracle FMS and the Oracle ESR payroll system and it was noted that all actions were completed from previous years. The overall conclusion was that assurance could be given that financial values were likely to be free from material misstatement, with 1 new recommendation made relating to the ESR reporting system, of medium priority, to be completed by December 2020.
ASSURE	<p>Counter Fraud</p> <p>The Committee received a comprehensive Position Statement summarising the recent Counter Fraud work carried out to date. The Position Statement highlighted that 35 days' work had been completed against the work plan, there were three cases currently under investigation with ongoing civil recovery which was due to be written off, as 50% of monies had been recovered but we had received no further payments for over a year and understood that HMCTS were unable to locate the debtor for recovery and that fraud awareness presentations were being offered to staff remotely via Teams in light of the pandemic. The Committee also received the NWSSP Counter Fraud Newsletter, which was approved.</p>
ASSURE	<p>Internal Audit</p> <p>The Committee received a comprehensive update from Internal Audit and in addition to the Position Statement, which highlighted progress against the Work Plan, together with an overview of other activity undertaken since the previous meeting. There were no significant issues in regards to completing the existing program of works that had been agreed, but Internal Audit continue to manage resources across the board. In addition, the Committee received the following reports for consideration:</p> <ul style="list-style-type: none"> • <u>Credit Card Expenditure Internal Audit Report</u> Achieved substantial assurance, with one medium and one low priority recommendations for action and did not identify any issues that would be classified as a weakness in the system control or design. • <u>Declarations of Interest Advisory Report</u> Noting that advisory reviews are not awarded assurance ratings, a review had been commissioned and findings highlighted four medium priority recommendations for action. • <u>COVID-19 Financial Governance Advisory Report</u> Noting that advisory reviews are not awarded assurance ratings, a review had been commissioned and findings highlighted nine suggestions for future improvements and it was agreed that an Action Plan would be developed to monitor progress against the considerations, given the changing nature of the pandemic.
ASSURE	Governance, Risk and Assurance

The Committee received comprehensive updates surrounding NWSSP COVID-19 matters, including Business Continuity Planning and COVID-19 Expenditure and Governance Arrangements.

Governance Matters - The Committee received the Governance Matters paper, which detailed the contracting activity from June 2020, to date and highlighted that there had been no departure from the Standing Orders but that NWSSP were looking to consider developing local Standing Financial Instructions.

In relation to contracting activity, during the reporting period, there had been 15 contracts let for NWSSP and 44 contracts let for NHS Wales, of which 13 were at briefing stage, 23 at ratification and 8 were extensions. It was noted no declarations were made as to gifts, hospitality or sponsorship since the last meeting and there had been no limited or no assurance audit reports. Where contracting activity related to the procurement of goods relating to COVID-19, these had been recorded centrally and each had been subject to robust governance and due diligence processes, which required a separate file note to be held.

In relation to the annual review of stores write-offs for the 2019-20 period, these had totalled £15,623, equating to 0.18% of total stock held and that full details were provided to the Committee. It was confirmed that all write-offs were actioned in accordance with the Stores Losses Protocol.

Audit Tracking - In relation to the tracking of audit recommendations, there were 205 recommendations, of which 197 were implemented, 7 were not yet due, and one had a proposed a revised deadline of 30/09/2021, for Committee approval. This recommendation related to cyber security and this was delayed in implementation due to the impact of COVID-19 and contractors not able to be present on site to complete the works surrounding the IT cabinet. The Committee were content to approve the revised deadline proposed.

Corporate Risk - The Corporate Risk Register highlighted 4 existing red risks, ten amber risks, one yellow risk and zero green risks, in the Risks for Action section of the Register. There remained one yellow risk in the Risks for Monitoring section of the Register and the Committee was reminded that the Register is reviewed at each SSPC, Audit Committee and Formal Senior Leadership Team meeting. The existing four red risks were summarised as follows and the Committee was informed that these long-standing risks had been progressed and would come off the Register in the coming months:

- Demise of Exeter Software System;
- The threat of a no-deal Brexit;
- NHS Digital plans to withdraw the Ophthalmic payment service; and
- The total quantum for addressing COVID-19 across Wales remaining fluid and uncertain.

Audit Committee Annual Report 2019-20 – The Committee received the seventh Annual Report, for approval, which highlights the activities and details the performance of Committee, assessing the work undertaken by Internal and External Audit, Counter Fraud and the Governance, Assurance and Risk staff at NWSSP. Appendices 1 and 2 detailed a full list of internal audits undertaken, with assurance ratings awarded and all internally generated reports and papers for the period. The Committee were content to approve the Audit Committee Annual Report 2019-20 and the document would be published bilingually, on both the staff intranet and NWSSP website.

Audit Committee Effectiveness Survey (ACES) Results – A summary of the outcome, together with an update as to the process for the 2020 review was provided to the Committee, stating that the survey comprised of 50 questions across six themes, which covered compliance with law and regulations governing NHS Wales, internal control and risk management, internal and external, counter fraud and Committee leadership. The results of the survey provided a rich source of information and provide assurance to the Committee in terms of existing arrangements and potential areas for development, for example, the continuation of virtual meetings. In terms of next steps, the Terms of Reference for the Audit Committee which form an annex to the Shared Services Partnership Committee Standing Orders, were in the process of being reviewed and would be brought back to the January 2021 meeting, for the Committee's approval.

INFORM	<p>The following items were received for Committee information:</p> <ul style="list-style-type: none">• Raising the Game; Tackling Fraud in Wales Report;• Audit Committee Forward Plan 2021-22;• NWSSP Annual Review 2019-20; and• NWSSP Freedom of Information Act 2000 Annual Report 2019-20.